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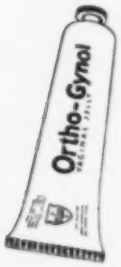

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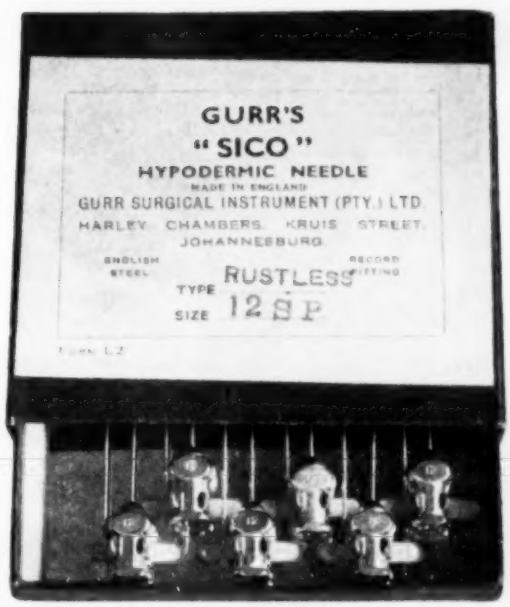

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TUBERCULOUS CERVICAL ADENITIS IN THE BANTU

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Surgeon, Non-European Hospital, Johannesburg

The treatment of tuberculous cervical adenitis in the Bantu is a serious socio-economic problem, particularly in the urban areas of South Africa. The lack of medical facilities makes ideal treatment impossible and the object of this paper is to sketch a plan of campaign for present-day conditions, and to make suggestions for a more rational approach to this difficult therapeutic problem.

THE POSITION IN SOUTH AFRICA

Almost all the overseas literature on tuberculous glands in the neck deals with European cases, and much of it is not applicable to the Bantu, for the important reason that in the Bantu the infection is due to the human bacillus.

It is generally accepted that in Europeans the bovine bacillus predominates as the causative factor in the formation of tuberculous glands. Figures given vary from 54% to 88%, but in the Bantu for practical purposes 100% of tuberculous glands are caused by the human bacillus. Tuberculous glands in the neck in children are closely related to pulmonary tuberculosis in the adult, and demand the same public health approach. Numerous examples of 2 or 3 children in one family suffering only from tuberculous glands have been noted, and investigations have led to the discovery of a case of pulmonary tuberculosis in an adult in the family. The other difficulty is the poor socio-economic position of most Bantu patients with tuberculous glands, and this makes general treatment difficult.

CLINICAL TYPES

The following clinical classification of localized cervical tuberculous adenitis is practical and will serve as a basis for discussion:

1. *Discrete Glands.* It is unusual for the Bantu child to be brought to hospital for discrete glands. They are usually discovered during routine examination when the child attends for some other disability such as diarrhoea, cough or sore throat.

2. *Central Necrosis with Matting.* A large proportion of patients attend at this stage. They are mostly school children referred to clinics by teachers, or pre-school children of the better type of parents.

3. *Skin Involvement but no Sinus Formation.* In a series of 100 cases analysed, this group represented just over 40% of the total. It is by far the largest group. Usually the pain caused by the skin involvement brings the patient to hospital, and the general condition is usually reasonably good at this stage.

4. *Sinus Formation and Collar-Stud Abscess.* This is also a common finding at the first attendance. These cases usually represent the poorest types, and they have usually been treated by their local 'Native doctor' before attending hospital.

5. *Hypertrophic Tuberculous Glands.* These are uncommon in young children. Most of them fall in the age group 15 to 25, and several cases in patients over 30 have been noted. The differential diagnosis from Hodgkin's glands is often difficult and a biopsy is usually necessary.

6. *Scrofuloderma.* This condition is also found more commonly in the older age groups. The extensive skin lesions following the crease lines in the neck and extending down to the axilla and anterior chest wall are so well known as to need no further description. The underlying glands are usually extensively involved and show a mixture of tuberculous and pyogenic infection.

THERAPEUTIC MEASURES AVAILABLE

Apart from routine general treatment, which will be discussed later, the following special means of treatment have been used extensively:

1. *Surgery.*
2. *Special Drugs*: Streptomycin, PAS, iso-nicotinic acid hydrazide and related compounds, and Streptokinase-streptodornase.
3. *Tubercle Endotoxoid.*
4. *X-ray Therapy.*

SURGERY

It is not necessary here to renew the controversy between the radical surgery recommended by the Edinburgh School and the conservative measures advised by the London School, though Hamilton Bailey [1] has become an advocate of radical surgery. Whatever one's views on the subject

admissions have to be kept down to a minimum when dealing with the Bantu on account of the lack of beds.

At the Non-European Hospital, Johannesburg, the following cases are admitted for surgical treatment:

1. *Cases with Typical Collar-Stud Abscess and Sinus Formation.* These cases are an absolute indication for radical surgery. With the large amount of necrotic tissue present it is illogical to expect streptomycin or any other therapeutic measures available to effect a cure.

Under a 3-day 'screen' of streptomycin the tract is widely opened and the necrotic tissue curetted out. It is not necessary to do the extensive skin excisions advised by Bailey. Local application of streptomycin, whether as a powder, lotion or ointment, have made the prognosis better and treatment shorter, and the results are usually satisfactory.

2. *Cases where the Diagnosis is Uncertain.* Hypertrophic tuberculous glands are usually biopsied to differentiate them from Hodgkin's glands. In adults a biopsy is indicated in about half the cases, but the operation can often be carried out in the out-patient department, if there is a shortage of beds. Recently a case was treated for 2 months with some apparent clinical improvement and on operation was found to be a spheroidal-celled carcinoma.

3. *Cases with Septic Foci.* Infected tonsils and septic teeth should be dealt with surgically after a short preliminary course of streptomycin and local hygiene.

4. *Cases of marked undernourishment* and living under very poor socio-economic conditions are admitted mainly for general treatment.

5. *Cases which show no improvement or deteriorate* after 3 weeks' treatment. These cases are admitted for further investigation and more active treatment, not necessarily surgical.

STREPTOMYCIN

Streptomycin may be given parenterally or locally. Unfortunately, under out-patient conditions it is only possible to give one injection daily, but occasionally arrangements can be made with municipal clinics or district nurses to have injections given twice daily, divided doses being more satisfactory. The usual course of treatment is ½ gm. daily up to the age of 2, 1 gm. daily up to the age of 10 and more according to age for adolescents and adults until 20 gm. have been administered.

The general effect is usually dramatic, provided septic foci have been dealt with and general treatment carried out in addition. The patient's appetite improves, the weight increases, the sedimentation rate, if raised, drops, but the local effects, except on sinuses, are less satisfactory. Streptomycin has little effect on discrete glands. The hypertrophic type usually regresses a little, but rarely more than 20%; glands with matting and central necrosis show little or no improvement. The only evident local improvement is with sinuses and these usually clear up, especially if streptomycin is applied locally as well. Cases of scrofuloderma do well with parenteral streptomycin, but clear up more quickly when it is applied locally in addition.

Local Treatment with Streptomycin. This, in our experience, constitutes probably the biggest advance in treatment over the last decade. The effect is dramatic, provided always there is no collar-stud abscess present. Powder, pastes, ointments and lotions have all been used. For sinuses and undermined ulcers probably a paste is best, but on the whole the most satisfactory results have been obtained with lotions. Daily dressings are the rule in the out-patient department, but in the wards the gauze covering the ulcer or sinus is kept moist by dripping on fresh lotion every four hours.

Experimental attempts have been made to reduce the dose of streptomycin to a minimum. Recently 3 cases with sinus formation were treated with 4 gm. of streptomycin each over one week (0.5 gm. by injection daily for 7 days, and the remaining 0.5 gm. in saline solution applied to the sinus in daily dressings) and all 3 cases were almost healed at the end of the week. A tuberculous ulcer of the thigh in an adult was treated with 3 gm. of streptomycin applied locally and healed completely in about 3 weeks, despite an active pulmonary focus. There is no doubt that the combined treatment is the ideal, but experiments have shown the importance of local applications to sinuses and ulcers.

Streptomycin, however, has a wider field, and can be applied locally to groups 2 and 3, i.e. caseating glands without sinus formation. In the pre-antibiotic days repeated aspirations occasionally resulted in fibrosis of the glands. Iodine and BIPP injections have been abandoned, though they proved their worth on occasions. Before streptomycin came into general use, penicillin was injected to prevent secondary infection and to deal with it if already present, and in most cases breakdown was prevented even with skin involvement.

The routine treatment to-day is to aspirate every gland which shows signs of fluctuation. The aspirated fluid is sent for microscopic examination and culture, and sometimes guinea-pig inoculation. A solution containing 1 gm. of streptomycin and 200,000 units of penicillin in 4 c.c. of normal saline is then injected. If possible, 1 c.c. of this solution is used but not more than two-thirds of the volume aspirated is replaced.

Cases with extensive skin involvement have cleared up and most glands fibrosed, provided general treatment was carried out. Strict asepsis and aspiration through normal skin are essential. About one-third of cases treated break down despite treatment, and these are then treated as sinuses. Injection treatment of one fluctuating gland in a matted mass of glands will improve the remaining glands, even without parenteral streptomycin.

During a period when only limited supplies of streptomycin were available, only local applications and injections were given and the results were satisfactory, but there is no doubt that, as far as streptomycin is concerned, the best therapeutic approach is to combine parenteral and local treatments, and this combined with general treatment is at present the main attack on tuberculous glands.

OTHER DRUGS

Other drugs used have been PAS and iso-nicotinic acid hydrazide and related compounds. These have not been used extensively enough to warrant an expression of opinion on their efficacy, but the first impressions are favourable.

PAS alone has a similar effect to that of streptomycin but milder, and in conjunction with streptomycin seems to enhance the beneficial effects of the latter. The disadvantage of giving tablets to an out-patient is that one is never certain that the treatment is carried out as ordered.

The iso-nicotinic acid hydrazide compounds have only been used on 2 or 3 cases so far, and it would appear likely that their effects will be similar to those of streptomycin and PAS, viz. a good constitutional effect with less marked beneficial local improvement.

Application of streptokinase-streptodornase is another recent addition to our therapeutic armamentarium. It is too early to give a definite opinion on final results, but there is little doubt that this form of treatment will be helpful in clearing up sinuses, particularly when secondary infection is heavy.

Tubercle Endotoxoid. Tubercle endotoxoid, introduced by Dr. E. Grasset, and made by the South African Institute for Medical Research, is a detoxicated solution of the bacillary bodies of a relatively avirulent tubercle strain, 'Saranec'. It is non-toxic to laboratory animals and its tuberculin content is very low. The dosages recommended by the Institute for children under the age of 14 years are:

1. For the first 8 doses, intracutaneous injections of 0.01 c.c. at intervals of 5 to 7 days.
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There has been much controversy about the efficacy of tubercle endotoxoid, but clinical experience with turberculous adenitis in the Bantu has been very satisfactory. Practically all cases treated at the non-European Hospital have a course of 'endotoxoid' injections at some time during the treatment. The clinical effect is similar to that of streptomycin in a milder form, the appetite improves, the weight increases and the general condition of the patient improves. The advantages over streptomycin, as far as out-patient treatment is concerned, are that injections are given at weekly intervals and can be maintained for months without danger of developing resistant bacilli. The course of 'endotoxoid' usually follows the 3 weeks' treatment with streptomycin, and to save time the first 2 injections can usefully be given during the streptomycin treatment. In this way the rapid beneficial effect of streptomycin can be maintained for months.

X-RAY THERAPY

Despite favourable overseas reports, the effects of X-ray therapy in tuberculous glands in the Bantu have proved disappointing, except for a few cases of the hypertrophic type. The beneficial effects in these cases appear to be related to the amount of reticulo-endothelial reaction in the gland. In the true hypertrophic type, almost tending to Hodgkin's, complete recession can be obtained, but usually the most one can expect is a 50% reduction in volume. The following methods have been tried:

1. Twenty-five röntgen units 3 times a week to a total of 900 r.
2. Daily doses of 100 r to a total of 900 r.
3. A more prolonged course of 50 r twice a week to a total of 1,200 r.

Over 100 cases were treated and considerable improvement was noted in cases with sinuses and most of these healed in 6 weeks, but the control group with streptomycin healed more rapidly. A few glands broke down during the treatment and on aspiration healed by fibrosis. The effect on the hypertrophic type of tuberculous glands has already been noted.

The general impression gathered from these cases is that X-rays are useful in decreasing the reticulo-endothelial reaction in tuberculous glands and in combating secondary infection when sinuses exist. The treatment, however, is long and costly and has been used less and less frequently, especially since the advent of the antibiotics.

OUT-PATIENT ROUTINE

All cases of tuberculous cervical adenitis get a complete physical examination, including chest X-rays, and in this the physician and paediatrician usually co-operate.

Blood counts and sedimentation-rate tests are done if the general examination warrants them. A large number of cases are referred to the ear, nose and throat department for specialized examination. Between 5 and 10% require tonsillectomy and this is usually done with streptomycin 'screening'. All patients are weighed at regular intervals and enquiries made about home conditions and diet, and attempts are made to improve conditions where necessary. In the earlier cases an attempt was made to get parents to take evening temperatures, but this was soon abandoned as inaccurate and unsatisfactory.

The following cases are admitted to hospital:

1. Cases with obvious collar-stud abscesses.
2. Cases in which a biopsy is considered necessary for a differential diagnosis.
3. Cases with obvious foci of infection, mainly tonsils and teeth.
4. Cases with marked undernourishment and in which the home conditions are unsatisfactory.

The remaining cases are then classified into 6 clinical group abovementioned.

General Treatment.

Attempts are made to improve diet and home conditions and to eliminate sources of infection. This is probably the most difficult aspect of the problem. However, with the help of municipal clinics, the welfare department of the hospital, and other channels, it is astonishing how much can be done. It is surprising how many parents are prepared to make sacrifices to give children extra milk, fruit, etc. and it is usually possible to arrange for a small meal to be given at the hospital at daily attendances. This is reinforced with Calciferol, cod-liver oil, vitamins, and Mist. Ferri Malt and other mixtures.

Local and Specific Treatment.

All cases are given daily injections of streptomycin for 3 weeks. During the last 2 weeks of this treatment, 2 injections of tubercle endotoxoid are interpolated and the endotoxtoid injections are continued after the 3 weeks at weekly intervals till 1 c.c. injections are reached. This is usually all that is required for discrete glands. Aspiration and replacement with the streptomycin-penicillin mixture is carried out in cases in Groups 2 and 3, usually at 3- or 4-day intervals. Sinuses and cases of scrofuloderma receive local daily dressings with penicillin and streptomycin.

The hypertrophic type is usually referred to the radiotherapy department, at the end of the 3 weeks' treatment, for an opinion and treatment if necessary.

All cases are examined regularly, and re-assessed at the end of 3 weeks, and if progress is not satisfactory the cases are admitted for further investigation. Depending on the reaction to treatment, numerous individual variations in the programme have to be made, and the above must be regarded as a general outline rather than a specific line of treatment. *It must be made clear that although all these special drugs and methods have been described and recommended, they are not always necessary.* Many early cases have cleared up with the general treatment recommended, and in mild cases it is well worth while to give this a trial before embarking on the more expensive and difficult part of the treatment.

DISCUSSION

It must be admitted that the treatment advised in this article is far from ideal and is not even the best treatment that could be given under existing conditions. It is simply a description of the treatment carried out at the Non-European Hospital, Johannesburg, which has given reasonably good results over a period of years, and which is probably practical in most hospitals.

The main improvement is almost invariably in the patient's general condition, but many of the cases show considerable local improvement as well. It should be noted that, apart from the general treatment advised, most cases receive 3 of the specific or local treatments, viz. streptomycin and other specific drugs, tubercle endotoxoid, surgery, and X-ray therapy.

It is obvious that the main weakness in this plan of campaign is the general treatment. Improved dietetic and socio-economic conditions are of paramount importance, and the attempts to deal with this aspect of the treatment are not satisfactory. Nursery schools for children with tuberculous glands, and convalescent centres for adults, are essential if we are to prevent relapses. In South Africa the ideal would be small villages for non-Europeans suffering from glandular and bone tuberculosis, in suitable districts. These would need to contain schools for the children, and suitable working conditions for adolescents and adults would be necessary. With correct supervision these centres could be almost self-supporting, and the capital outlay would be reasonable when compared to the building of new hospitals.

It is useless to admit cases to hospital for a few weeks, clearing up the condition and then to send the patient back to unsatisfactory home conditions. Relapse is almost inevitable. This was well illustrated in the case of a boy of 12 who had been in a reformatory on and off for 6 years. During his first sojourn in the reformatory he was treated for tuberculous adenitis in the right side of the neck. After several weeks' treatment a block dissection was possible and he was discharged from the reformatory with no evidence of glands and in good general condition. He was sent back to the reformatory 6 months later, following some misdemeanour, in a poor general condition and suffering from a tuberculous ankle joint. This also cleared up and resulted in an ankylosed joint without any evidence of activity. Nine months after discharge he was sent back again and this time he was treated for a tuberculous gland in the left side of the neck, which also cleared up with treatment but without block dissection. During a fourth incarceration in the reformatory he was treated surgically for a tuberculous adenitis of the inguinal glands with block dissection. Investigations have shown that the source of his infection is almost certainly an 'aunt' with a pulmonary focus, and the lack of social amenities and deficient diet resulted in lowered resistance and 4 re-infections.

A vast socio-economic revolution would be required to deal with this and other forms of tuberculosis adequately, but in the meantime much can be done through the existing channels and the foundation of suitable villages as suggested.

SUMMARY

1. A plan of campaign has been suggested for the treatment of tuberculous cervical glands in the Bantu in Johannesburg, and the treatment given at the Non-European Hospital, Johannesburg, has been described.

2. The deficiencies in the treatment advised have been discussed and suggestions have been made to deal more effectively with the problem of tuberculous adenitis in the Bantu.

REFERENCE

1. Bailey, H. (1948): Lancet, **1**, 313.

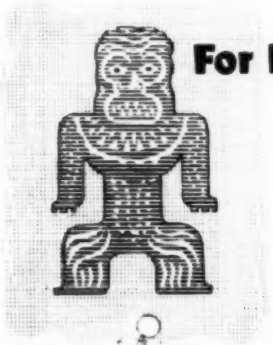
ABSTRACT

Plasma Augmenters in Clinical Surgery. Ohike, R. F. and Scales, J. J. (1953): Canad. Med. Assoc. J., **68**, 260.

The authors observed the clinical results in a series of 116 cases in which polyvinylpyrrolidone (P.V.P.) or Dextran was used in the restoration of circulating blood volume. One or the other of these products was given to patients with a falling blood pressure and rising pulse rate. In addition, whole blood was given to patients who had obviously lost excessive blood. Blood pressure was maintained or raised to the required level in the majority of patients by the use of either P.V.P. or Dextran. The response to either P.V.P. or Dextran was proportional to the rapidity of the infusion. Early administration of the plasma augmenters was found valuable in preventing or eliminating reduction in blood pressure.

No typing, cross-matching or Rh determinations were found necessary in administering P.V.P. or Dextran. The products were stored indefinitely at room temperature. No complication followed administration of the plasma augmenters.

Subsequent to the submission of the paper, 150 additional patients were given P.V.P. or Dextran without complication.



For Diseases Common in the Tropics and Subtropics . . .

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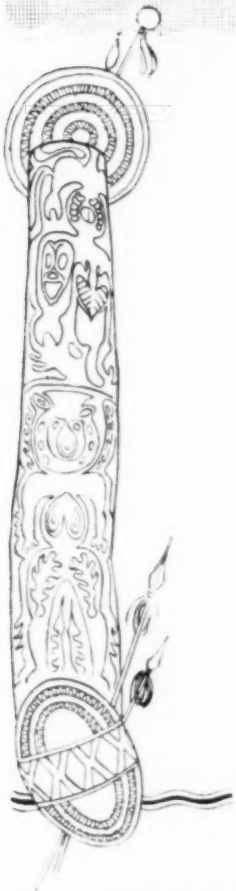

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Q Fever
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Plague · Tularaemia
Undulant Fevers

Intestinal Fluxes:—
Cholera
Bacillary Dysentery
Amoebic Dysentery
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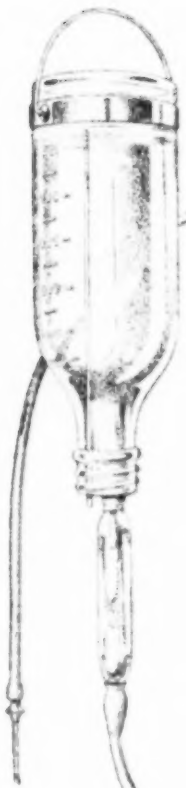

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VAN DIE REDAKSIE

DIE ARITMIE VAN DIE HARTVOORKAMER

Die aritmie van die hartvoorkamer—ontydige sistool, tachikardie, siddering en trilling—was met merkwaardige deeglikheid deur Sir Thomas Lewis bestudeer, en sy teorie van ‚sirkusbeweging' wat op siddering en trilling toegepas was, is lank algemeen aanvaar. Sy studie van die hartvoorkamer moes by baie die indruk gelaat het dat die onderwerp grootliks begryp word, maar soos so dikwels die geval is was dit beperking van tegniek wat die bepaling van finale gevolgtrekkings verhoed het. So was diegene wat in kardiologie belangstel nie in staat om direkte waarnemings te maak nie van wat gedurende normale sinusritme en die hartvoorkameraritmie in die hartvoorkamer van die mens se hart, of dié van die proefdier, gebeur. Lewis se werk is gereeld in standaardwerke oor geneeskunde, kardiologie, fisiologie en farmakologie aangehaal, en dosente in hierdie onderwerp het melding van die sirkusbeweging gemaak sonder om alternatiewe teorië aan te bied, en met die behandeling van hartvoorkamersiddering en -trilling is die uitwerking van die geneesmiddels wat gebruik was algemeen toegeskrywe aan die uitskakeling van die prikkelbare gaping in die sirkusgolf van sametrekking.

In 'n gedenkwaardige monografie bied Prinzmetal en 12 ander skrywers nou die eksperimentele en kliniese materiaal en metodes aan waaruit hulle 'n konsep van die eenheidsaard van die hartvoorkameraritmies ontwikkel het. Dit is bewys dat die 4 aritmies 'n gemeenskaplike wyse van oorsprong het, naamlik die uitstroming van prikkelings van die ektopiese fokus in die hartvoorkamers. By ontydige sistool van die hartvoorkamer, hewige hartvoorkamertachikardia en hartvoorkamersiddering sprei die sametrekkingsgolwe en elektriese prikkel van die ektopiese fokus buitewaards *in alle rigtings* deur die hartvoorkamerspiere; by hartvoorkamertrilling, waar chaotiese bedrywigheid in klein spierdeeltjies dwarsdeur die hartvoorkamers voorkom, is daar 'n direkte verhouding van die chaotiese bedrywigheid tot die snelheid waarmee die prikkeling van 'n ektopiese fokus uitstroom. Daar is 'n verskil in graad liewer as in aard van die onderliggende verstorings by hierdie toestande. Die opvatting word in die monografie voorgelê vir die oorweging van navorsers wat in hartvoorkameraritmie belangstel en sal vir mediese studente en klinikusse met hul studie van die betrokke meganismes van waarde wees.

Die waarnemings wat in die monografie gerapporteer word dui aan dat die sirkusbeweging-teorie nie aanvaarbaar is nie. Die werk van Lewis is herhaal en uitgebrei. Die gang van die hartprikkel is deur elektrokardio- en trillingsgraaf aangeteken en kinematografiese rekords van die aritmies, wat by die mens òf spontaan

EDITORIAL

THE AURICULAR ARRHYTHMIAS

The auricular arrhythmias—premature systole, tachycardia, flutter and fibrillation — were studied remarkably thoroughly by Sir Thomas Lewis, and his theory of 'circus movement' applied to flutter and fibrillation has long been widely accepted. His study of the auricular arrhythmias must have given many the impression that the subject was largely understood, but as has so often been the case, it is limitation of technique that has prevented the establishment of final conclusions. Thus those interested in cardiology have been unable to make direct observations of what exactly happens in the auricles of man or the experimental animal during normal sinus rhythm and the auricular arrhythmias. Lewis's work has been regularly mentioned in standard text-books of medicine, cardiology, physiology and pharmacology, and teachers of these subjects have mentioned the circus movement without presenting alternative theories, and in the treatment of auricular flutter and fibrillation the effect of the drugs used has generally been ascribed to abolition of the excitable gap in the circus wave of contraction.

In a monumental monograph Prinzmetal and 12 other authors now present the experimental and clinical material and methods from which they have evolved a concept of the unitary nature of the auricular arrhythmias. The 4 arrhythmias have been shown to have a common mode of origin, namely the discharge of stimuli from an ectopic focus in the auricles. In auricular premature systole, auricular paroxysmal tachycardia and auricular flutter the contraction waves and electrical impulses spread outward from the ectopic focus *in all directions* through the auricular muscle; in auricular fibrillation, where chaotic activity occurs in small muscle-segments throughout the auricles, there is a direct relation of the chaotic activity to the rapid rate of discharge of stimuli from an ectopic focus. There is a difference in the degree rather than in the nature of the underlying disturbance in these conditions. The concept is submitted in the monograph for the consideration of research workers interested in the auricular arrhythmias, and will prove valuable to medical students and clinicians in their understanding of the mechanisms involved.

The observations reported in the monograph indicate that the circus movement theory is untenable. The work of Lewis has been repeated and extended. The course of the cardiac impulse has been traced by electrocardiograph and oscillograph, and cinematographic records of the

voorkom of deur eksperiment veroorsaak word, is gelyktydig met indirekte elektrokardiogramme en dié met esofaguskontak geneem. Hierdie studies tesaam met inligting wat ingewin is van pogings om die hipotetiese sirkuspad deur brand, sny, vries, of verwydering van een hartvoorkamer te versper, het bewys dat die sirkus-bewegingteorie ongeldig is.

Die ondersoek het 'n herwaardering genoodsaak van die uitwerking van die geneesmiddels wat lank gebruik is om hartvoorkamersiddering en -trilling te beëindig. Die ouer teorie dat hierdie anti-aritmiese middels hartvoorkamer-aritmie beëindig deur die prikkelbare gaping op die sirkuspad uit te skakel, word nou as foutief bewys, en hulle uitwerking kan sonder verwysing na die sirkus-beweging-teorie verduidelik word.

Die werk van Prinzmetal en sy kollegas sal aanleiding gee tot baie veranderings in die konsep, die kliniese oorweging, die onderrig en die terapie van hartvoor-kameraritmie. Dit moet nie aanvaar word nie dat die onderwerp nou grotendeels opgehelder is nie; inligting word byvoorbeeld verlang oor:—,Die uitwerking van geneesmiddels, veral digitalien, op die hartvoorkamers; verdere kinematografiese studie van die hartvoorkamers van die mens se hart, veral die linkerhartvoorkamer; die aard van die hartvoorkamer se geleidingsisteem; sekere aspekte van die aard van hartvoorkamertrilling; hierdie en baie ander probleme wag op toeligting'. Die uitstekende monografie waarna verwys word dien as padwyser.

The Auricular Arrhythmias (1952): deur Prinzmetal, M. *et al.* Springfield, V.S.A.: Charles C. Thomas.

arrhythmias spontaneously occurring or experimentally produced in man have been made simultaneously with indirect and oesophageal lead electrocardiograms. These studies combined with information obtained from attempts to block the hypothetical circus path by burning, cutting, freezing, or removing one auricle, have demonstrated that the circus movement theory is invalid.

The investigation has necessitated a re-evaluation of the action of the drugs that have long been used to terminate auricular flutter and fibrillation. The older theory that these anti-arrhythmic agents terminate the auricular arrhythmias by abolishing an excitable gap on a circus pathway is now shown to be erroneous, and their action can be explained without reference to the circus-movement theory.

The work of Prinzmetal and his colleagues will lead to many changes in the concept, the clinical consideration, the teaching and the therapy, of the auricular arrhythmias. It must not be thought that the subject is now largely understood; the following matters among others still need to be considered: 'The action of drugs, especially digitalis, on the auricles; further cinematographic study of the human auricles, particularly the left auricle; the nature of the auriculo-ventricular conduction systems; certain aspects of the nature of auricular fibrillation;—these and many other problems await elucidation'. The magnificent monograph referred to shows the way to proceed.

The Auricular Arrhythmias (1952): by Prinzmetal, M. *et al.* Springfield, U.S.A.: Charles C. Thomas.

THE MORRIS SPLINT FOR MANDIBULAR FRACTURES

DAVID S. DAVIES, *O.B.E.*, D.M. (OXON), F.R.C.S. ED., LINDSAY BARCLAY, *M.B.E.*, L.D.S.,

and

THOMAS C. WILSON, H.D.D., L.D.S.

From the Plastic Department, Groote Schuur Hospital, Cape Town

The object of these notes is to draw the attention of surgeons dealing with jaw fractures to the advantages of the Morris[1] splint. We have used it during the past 3 years in the Maxillo-Facial Section of the Plastic Department of the Groote Schuur Hospital, and are convinced of its superiority in most respects.

CAP-SPLINTS

We must say here that the majority of cases in this series, which amounts to over one thousand, have been treated by our dental surgeons entirely with cap-splints. These fractures occur mostly among non-Europeans as the result of assaults and most of the patients have good teeth, so that the larger proportion lend themselves admirably to treatment with cap-splints, always provided that teeth in the fracture line are removed forthwith, while the cap-splints are being prepared. Another factor leading to our choice of cap-splints is the shortage of beds. Despite the size of our fracture clinic we have no beds allotted for these cases, so that except in rare instances we must treat

Fig. 1. Brenthurst splint claws.
Fig. 2. Brenthurst splint in position on mandible showing collars, arms and universal joint.
Fig. 3. Bilateral Brenthurst used for long oblique fracture of mental region with much overlapping. Shows a method of getting fixation around a corner without using a central claw.
Fig. 4. Typical dimpled scar left by Brenthurst claw.
Fig. 5. Stader splint showing Stader screw-jack for distraction or approximation of fragments. Roger Andersen pins and clamps.
Fig. 6. Roger Andersen pins on anterior fragment. Posterior fragment controlled by Brenthurst claw.
Fig. 7. Clouston Walker pins with Stader screw-jack as connecting bar.
Fig. 8. Use of Stader pins for anterior fracture and Brenthurst splint for posterior.


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them as out-patients. The success attending our selection of treatment is high-lighted by the fact that throughout our series of jaw-fracture cases, about 80% of which continued treatment until discharged, we had only 2 cases of non-union, one with diabetes and tuberculosis and one coming late under treatment with heavy infection. Our criterion of cure has been good firm clinical union. Having established early that X-ray appearance of bony union

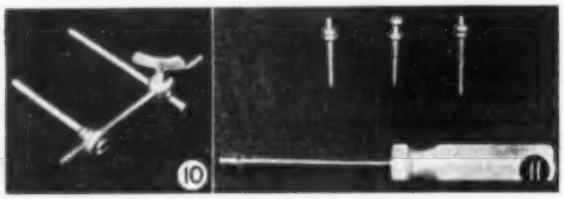

Fig. 10. Bigelow type of screw. Berry type of screw.
Fig. 11. Morris screws and screwholder.

lagged far behind clinical healing we considered it unnecessary, in face of favourable clinical signs, to overburden the already overtaxed radiography department. Finally there is no doubt at all that from the patient's point of view treatment with cap-splints is the most gentle and painless. The skill of our dental mechanics has led to consistent success and made cap-splints the treatment of choice. Wherever cap-splints are suitable they should be used, and it will be found that with experience the indications for all forms of wiring and external splintage diminish.

In certain cases, cap-splints are inapplicable. Where the teeth are too few, too loose or too septic to act as supports, or where they are badly placed for intra-oral splinting, external splintage is called for. In our series, the Brenthurst splint was used in 46 of the earlier cases,

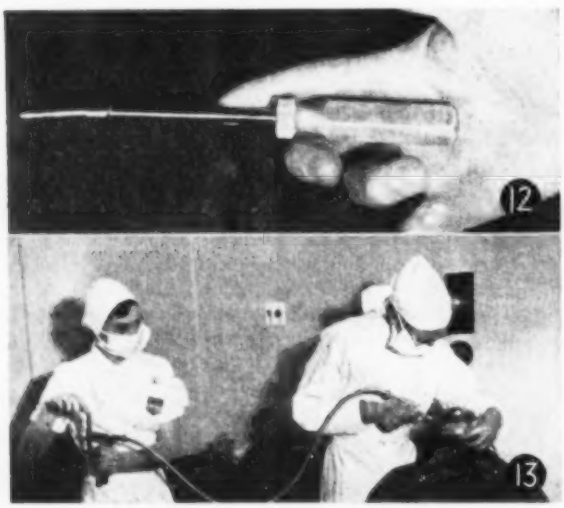

Fig. 12. Morris screwholder carrying its screw for driving.
Fig. 13. Showing method of using Stader drill.

26 of them bilateral, Roger Andersen pins in 9, the Stader splint in 9, and the Morris splint in 11 of the more recent cases.

CLAWS

The Brenthurst splint, as may be seen from the photographs, consists of a pair or trio of three-pronged claws, which are made to grip the lower border of the mandible. The claws do not penetrate the cortical bone, and yet take a powerful grip of the jaw fragment so that complete and accurate reduction of the fragments can be carried out at the original operation. The fact that the claws do not penetrate the bone is an additional safeguard against the introduction of sepsis into the bone, and we have used this splint many times in the presence of marked infection, without mishap. The Brenthurst's sole disadvantage seems to be that it leaves dimpled scars under the jaw margin, which men find difficult to shave and women find somewhat disfiguring. Where we have used an incision crossing the fracture sites for ease of application and reduction, the scar is of course more marked.

PINS

The insertion of pins is easy in theory but in practice there are numerous difficulties. You are trying to drive a pin through two layers of very hard cortical bone. The Stader, Roger Andersen and Clouston Walker pins, as may be seen from the photographs, must be inserted obliquely and not vertical to the surface. The pins must avoid the inferior dental canal, the facial artery and the region of the tooth roots. You must use considerable force to insert the pins but must not overshoot the mark and let the pin enter the soft tissues deep to the bone. Remember also that the pin is being inserted obliquely into an unsupported wobbly fragment which can only be partly steadied by a finger in the mouth. These then are the difficulties; the advantage is a practically invisible scar. Bone infection is very uncommon but theoretically, with a pin which traverses cortical layers and medulla (as it must do to get a firm grip), there will always remain the possibility of bone infection and we have not tried to use these splints in obviously infected cases. We have taken such liberties only with the Brenthurst.

SCREWS

Screws of various types, usually of vitallium, have been described, such as the Bigelow and Berry types here illustrated, but their insertion is not as easy as with the Morris, nor have their fixation systems the adaptability and strength of the Morris. We consider the Morris

Fig. 9. Fracture of symphysis region treated by locally made pins and Stader screw-jack. Photographs show scars left by pins.
Fig. 14. Morris splint in place on mandible showing adjustable temporary fixation bar which may be removed after plastic bar has been applied as shown.
Figs. 15 and 16. Morris splint as worn after removal of temporary fixation bar.
Fig. 17 and 18. Morris splint used with Stader screw-jack which is removed when plastic bar is in place.
Fig. 19. Showing scars left by Morris screws.


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splint to be the splint of choice for external splintage where sepsis is not present.

As shown in the illustrations, the Morris screws are of the wood-screw type, which, once started, take themselves into the bone by mere turning and do not need any marked thrust. We soon realized that a great disadvantage of pins was that the hand that supplied guidance and direction had to supply the force also, except in the case of the Stader pin. This made for difficult insertion and it was disappointing to find that often, in our hands, the grip obtained was poor. We now use a spear-pointed drill made from a dental burr to start a small hole in the cortex at the selected site. This allows a twist drill of a size appropriate to the screw to start cutting into the bone straight away without slipping, and for this purpose we have found the Stader drill very convenient. The pistol grip allows the operator's hand to guide the drill accurately, while any assistant may supply the drilling force by steadily turning the distant handle. The drill works slowly so that there is no fear of overheating the bone or of overshooting the mark. The drill being removed, the Morris screw, which is firmly held by its screwdriver, is inserted and takes itself into the bone on turning the holder; the insertion is effortless, sure and controlled at all times. With all three screws in place, the fragments are reduced and held firmly by the special retaining bar, which through its universal joints can take up any position necessary, and on tightening will hold the fragments in place while a quick-setting plastic bar is moulded around the screw heads. The plastic bar once set, the metal bar can be removed and is ready for the next case. We have introduced a small modification here by using the Stader screw-jack bar instead of the Morris bar. This allows of gradual distraction or approximation of the fragments and, if necessary, readjustment of their position in the first day or two, so that one may be absolutely certain of correct positioning before the plastic bar is added and the screw-jack removed. The Morris screws, being vitallium, are exceedingly well tolerated by the tissues, and at the end of 6 weeks have as good a grip of the bone as in the first week. Furthermore, their removal is simple. The plastic bar is cut through and split open near the head of the screw and the screw unscrewed from the bone. We have not yet needed even a local anaesthetic for this, the process seeming painless.

If it is desired to test the state of union, the bar can be cut across with a dental drill, and, should further fixation be indicated, the gap in the plastic bar is 'welded' with another dab of material after a few holes have been bored in the adjacent ends of the bar in order to give the plastic weld a grip. Finally, as the photographs show, there is no residual scarring.

SUMMARY

In a series of over 1,000 cases of fractured mandible, a certain number needed external splintage. The advantages of the Morris splint for these is pointed out.

I should like to thank the *Journal of the South African Dental Association* for permission to reproduce certain of the photographs and data, and Dr. Norman Petersen, F.R.C.S., Chief Plastic Surgeon at Groote Schuur Hospital, for permission to report on this material, most of which was seen at the Maxillo-Facial Section of his Department.

REFERENCE

1. Morris, J. H. (1949): Oral Surg. Med. Path., **2**, 1382.

PIGMENTATION OF LIPS AND BUCCAL MUCOSA ASSOCIATED WITH INTESTINAL POLYPOSIS

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Department of Surgery, University of Cape Town

This rare but significant clinical combination has been variously reported in the literature. No mention of it is to be found in representative surgical or medical textbooks.

Although the peculiar distribution of the pigmentary pattern had been previously recorded the first to stress its association with intestinal polyposis was Peutz [2] of The Hague, 1921. This 'syndrome of Peutz' as it is called by Touraine and Couder [4] of Paris occurred in a family of which several members manifested the characteristic pigmentation and intestinal polyposis. Later in 1949 Jeghers *et. al.*[5] recorded a collected group of 10 cases and found only 11 other proven cases in the literature. Since then Tanner [6] and Reynard [10] each added a further case with a review of the literature (1951), and Schaffer and Sachs [11] and also Wolff [7] reported 2 cases (1952). More recently Kitchin [8] encountered 2 cases and Kaplan and Feurtwanger [9] recorded a case in the Middle East (1953).

Four cases are reported here with a brief discussion of the syndrome and its significance.

CASE 1

A 22-year-old European married woman was admitted to hospital on 28 December 1942. She was 7 months pregnant and had been vomiting intermittently for 48 hours. The vomiting was associated with vague abdominal cramps. Constipation had been absolute for 24 hours.

On examination the patient, who was a fair-skinned, fair-haired, blue-eyed female, showed the characteristic oral pigmentation. The significance of the latter was unfortunately not appreciated by the author or his colleagues at that time. In consultation with the gynaecologists, the vomiting was attributed to toxaemia and the cramps to probable uterine contractions.

The cramps and vomiting persisted in spite of gastric suction and intravenous therapy. The patient progressively deteriorated and a Caesarian section was performed 96 hours after the onset of vomiting. A live male child was delivered. At operation the patient was found to have an entero-intussus-

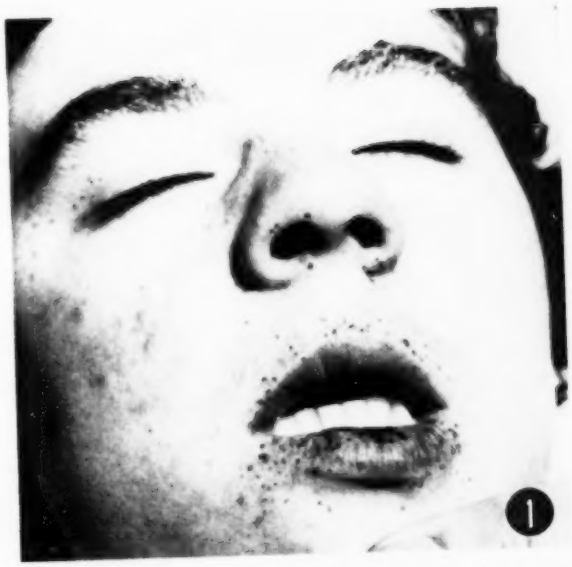

Fig. 1. Case 3, showing the typical distribution of pigmentation round the mouth and on the mucosa of the lips.

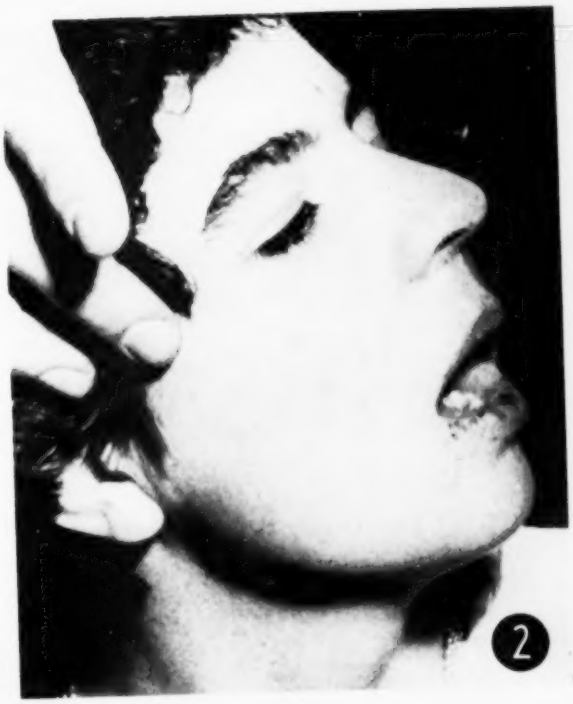

Fig. 2. Case 3, showing the pigmentation on the lips and on the inside of the cheek.

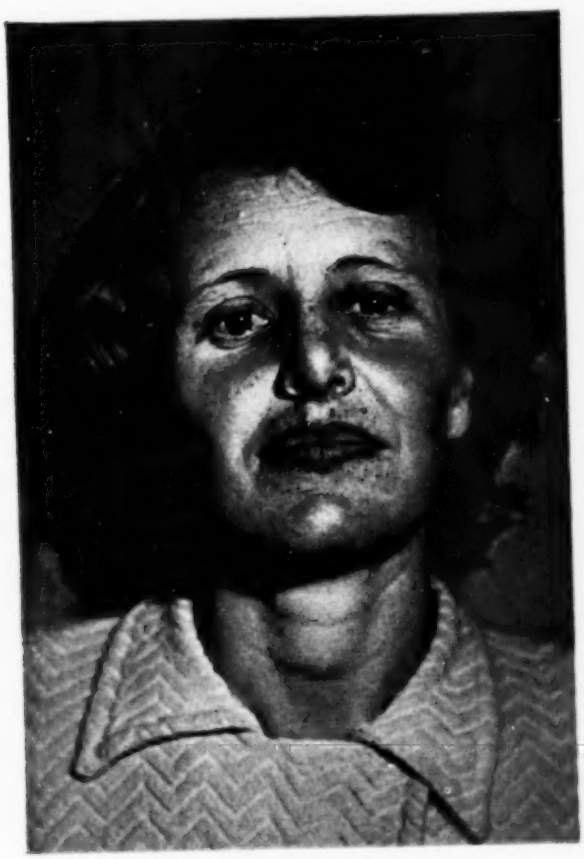

Fig. 3. Case 4, illustrating the distribution of the pigmentation in a fair-haired subject.

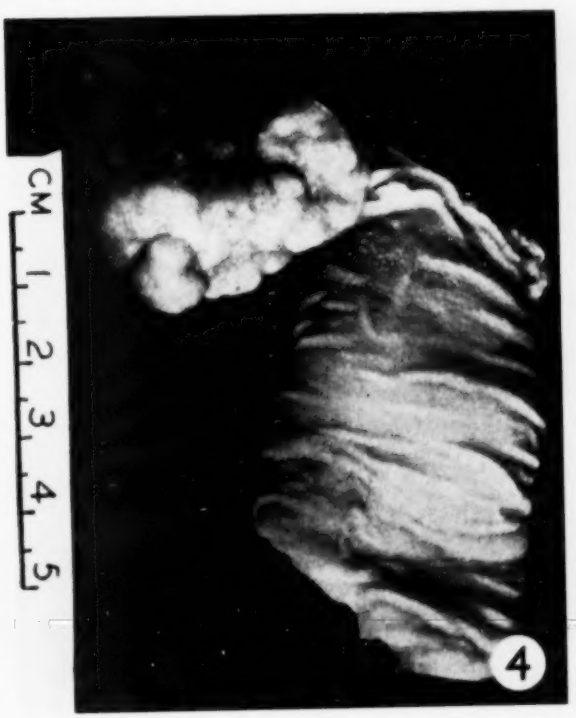

Fig. 4. Specimen of segment of bowel resected from case 3 with a typical pedunculated polyp. The bowel has been everted to show the polyp on the mucosal surface.

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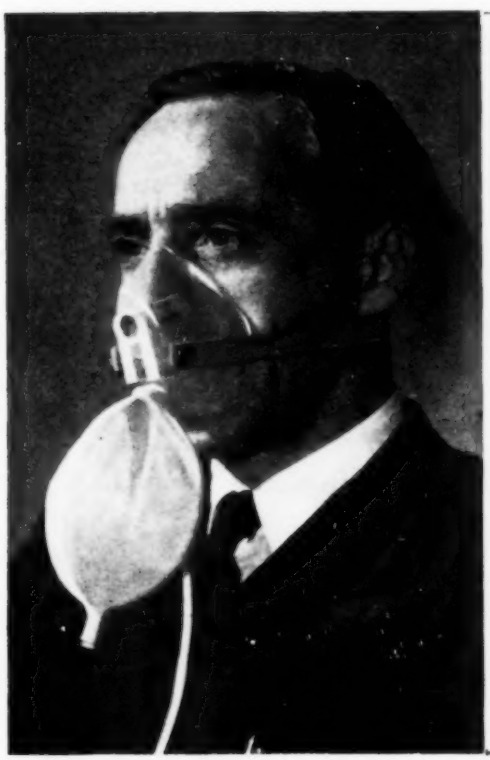

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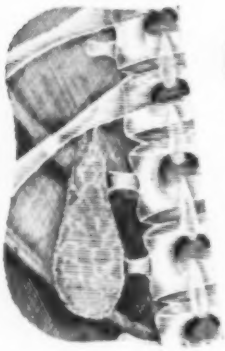

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ception with 12 in. of gangrenous bowel. The intussception had been initiated by a single walnut-sized polyp in the jejunum.

The patient died in irreversible shock on the third post-operative day.

CASE 2

A 56-year-old Englishwoman was sent into hospital (in England) by her general practitioner as a case of intestinal obstruction on 15 September 1951. She had been having intermittent abdominal pain for 12 hours and had vomited twice. There had been no previous attacks.

On examination the patient was a thin woman with dark greying hair and olive complexion. She had brown eyes. The typical markings described were present, confined to the skin around the mouth and the mucosa of the lips. Examination of the abdomen was negative and no distended bowel or fluid levels were evident on straight X-ray of the abdomen.

All symptoms disappeared after 12 hours of gastric suction and intravenous fluid therapy. Treatment was suspended pending investigation.

Three days after admission the patient's symptoms recurred in hospital. She was operated on to relieve small-bowel obstruction and was found to have an early ileo-colic intussusception initiated by a single pedunculated polyp in the ileum, one inch from the ileo-caecal junction. A hard lymph node was encountered in the mesentery one inch from the polyp. Four inches of the ileum containing the polyp, with a wedge of mesentery including the lymph node, were resected. No other polyps were palpated in the small bowel.

Convalescence was uneventful.

The tumour, which was macroscopically and histologically indistinguishable from the polyps in the other cases, showed considerable melanotic pigmentation in the stroma. This was the only case in which pigment was seen in the intestinal lesion.

No follow-up on this case has been possible.

CASE 3

A 20-year-old European girl was admitted to Groote Schuur Hospital on 7 December 1952 for removal of a suspected intestinal polyp.

One year before admission she had experienced an attack of abdominal cramps with vomiting. This attack subsided in a few hours. Subsequently she had a series of similar attacks, and in March 1952 she had an operation and an entero-colic intussusception was reduced. In July she underwent a further operation at which a similar intussusception was reduced. The pains however continued and she was sent to this hospital for opinion and treatment.

On examination the patient who had very fair skin, with dark hair and brown eyes, showed the characteristic buccal pigmentation (Figs. 1 and 2). There were no other noteworthy findings.

At operation the polyp was encountered 10 inches above the ileo-caecal junction. Four inches of bowel containing the polyp were resected (Fig. 4). No other polyps were palpated in the small bowel.

The histology was that of an adenomatous polyp of the small bowel.

Convalescence was uneventful and to date there has been no recurrence of symptoms.

CASE 4

On 6 May 1953 a married European woman aged 32 was referred to Groote Schuur Hospital for removal of an intestinal polyp. On 7 June 1952 the patient had experienced severe abdominal cramps and vomiting; 3 hours later she was operated on to relieve small-bowel obstruction. At this operation her condition was reported as being too bad to permit resection. On admission the patient was found to be fair-haired and blue eyed, with the characteristic buccal melanin pigmentation (Fig. 3). There were no other abnormal findings. A laparotomy was performed. The patient was found to have intussuscepted again. The intussusception was reduced and the polyp encountered 3 feet above the ileo-caecal juncture. Four inches of bowel containing the polyp were resected. Careful palpation revealed no other polyps in the small bowel.

The histology was that of a benign adenomatous tumour.

Convalescence was uneventful.

The pigmentation in all these cases was very striking and conformed with Siemen's[3] description of 'ephilides inversae'. The pigment occurred on the mucosa of the lips and round the mouth, areas which are usually immune even in freckled subjects. The pigmentation was punctate in distribution and varied from black to brown. The marks could not be obliterated by lipstick. In only one case (Fig. 3) was this pigment inside the mouth. Others record pigmentation inside the mouth.

The presence of pigment on the fingers has been described as characteristic of these cases. Case 4 showed some pigment on the fourth finger of her right hand. However, freckling of the fingers is not uncommon and can hardly be regarded in the same light as the characteristic buccal pigmentation.

The pigment has been confirmed as being melanin in one of the cases reported by Jeghers.[5] No biopsy was done in the present series.

The skin lesions had been present as long as the patients could remember. In only case No. 3 was it possible to establish beyond doubt that the lesions had been present at birth.

The polyps in all these cases were pedunculated and occurred in the small bowel (Fig. 4). They all presented as intussusceptions. In every case only one polyp was found and no others were encountered on palpation of the small bowel at operation. No thorough search was instituted for polyposis of the colon. Clinically, however, none of the patients revealed any suggestion of colonic involvement. Others report multiple polyposis of the small bowel and associated colonic polypi but an analysis of the reported cases indicates a distinct predominance in the small bowel.

The histology was consistently that of a benign adenomatous polyp and in only one case was pigment detected. No previous record of pigment in a polyp has been found.

Two of the patients were fair-haired. Three had very fair skins.

In only one case (No. 4) was it possible to establish any relevant family history. Two of this patient's brothers had the typical pigmentation around the lips and mouth but by middle life had shown no symptoms or signs that could be attributed to polyposis. Only one other case in which the pigmentary part of the syndrome existed alone could be found in the literature and in spite of an awareness of the syndrome no other cases have been seen by the author.

There is, however, presumptive evidence in a full review of all recorded cases that the syndrome is familial and is transmitted as a Mendelian dominant. Hutchinson's[1] twins, Peutz's[2] family and Case No. 4 in this series presented a familial incidence of pigmentation.

The syndrome has been encountered in both sexes. It has been reported in all age groups with a predominance in the second and third decades, when it usually presents as intestinal obstruction.

It has generally been thought to occur in dark people and in dark races. In this group 3 were fair-skinned and 2 had fair hair. Two were of Dutch and 2 of British descent. No race predominance can be established.

No adequate explanation can be formulated and none is attempted to account for this peculiar but constant clinical association.

SUMMARY AND CONCLUSIONS

1. Four cases manifesting peri-oral and buccal pigmentation with associated intestinal polyposis are reported.

2. The syndrome occurs in both sexes and all races and more commonly presents as intestinal obstruction in the second and third decades.

3. The recognition of the pigmentation provides reliable and useful diagnostic evidence of polyposis in patients presenting symptoms of intestinal obstruction or other symptoms attributable to polyposis.

My thanks are due to Professor Erasmus for his interest and for his assistance in the illustration of this paper.

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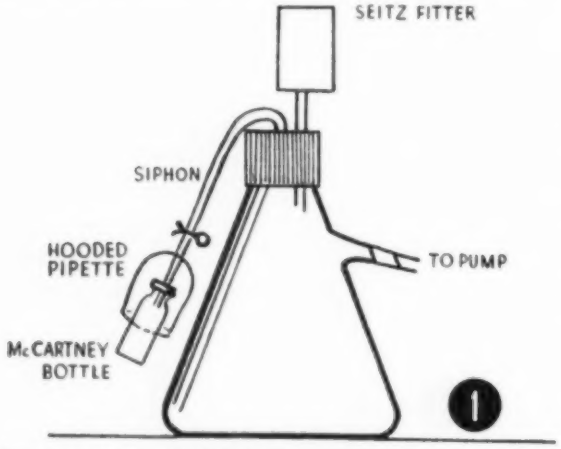
A PRELIMINARY REPORT ON THE USE OF A MODIFIED TECHNIQUE FOR THE MANUFACTURE OF KIRSCHNER MEDIUM

C. H. L. HOWELLS, B.Sc., M.B., *and* O. F. GIBBS, Reg.D.

MEDICAL TECHNOLOGIST

*King George V Hospital, Durban**

Kirschner (1932) described a semi-synthetic medium which has proved to be of considerable value for the isolation of *M. tuberculosis* from sputum, pleural fluid, C.S.F., and other pathological materials. A modification of the original formula has been described by Vollum (1952) in which the proportions of the phosphates are altered, phenol red is added as an indicator, and penicillin is incorporated to inhibit contaminants. The salt solution is



dispensed in appropriate amounts and autoclaved. Sterile horse-serum containing the appropriate amount of penicillin is then added aseptically to the sterile basic medium.

The present communication describes a modification in the method of preparation which considerably reduces the labour involved and also the chance of contamination.

PREPARATION

$Na_2HPO_4.12H_2O$	19.0 grams
KH_2PO_4	2.0 grams
Magnesium Sulphate	0.6 grams
Sodium Citrate	2.5 grams
Asparagin	5.0 grams
Distilled water	1,000 ml.
To this solution add:	
Glycerol	20 ml.
Phenol red 0.4% solution	3 ml.
To 900 ml. of this solution add:	
Horse serum	100 ml.
Penicillin 10,000 units/ml.	10 ml.

The completed solution is then filtered through a Seitz filter, using Ford Sterimats, grade S.B., and distributed into McCartney bottles by the syphon arrangement as illustrated.

Preliminary tests using Kirschner Medium prepared by this technique indicate that there is considerable saving of time, and that there is no disadvantage engendered by its adoption. So far, 30 specimens have been tested in parallel, using media prepared by the original and the modified methods; but a full experimental report will be available in due course.

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Our thanks are due to Dr. R. L. Vollum for reading the typescript and to Miss M. Schofield for the drawing of the apparatus.

* Dr. Howells is working under the auspices of the Tuberculosis Research Association, and Mr. Gibbs is employed by the Council for Scientific and Industrial Research.

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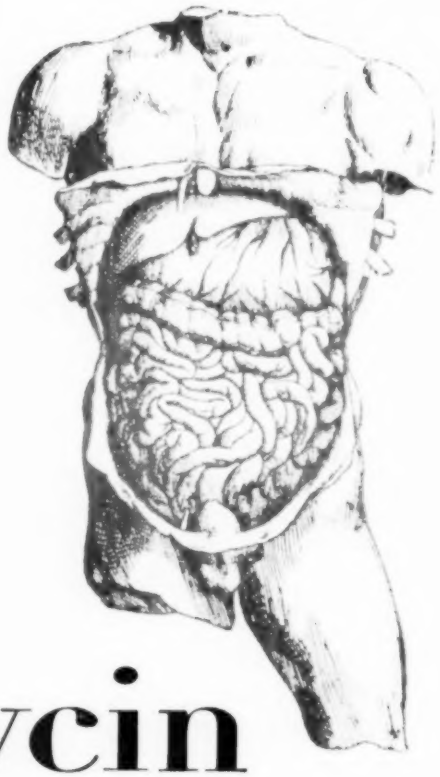

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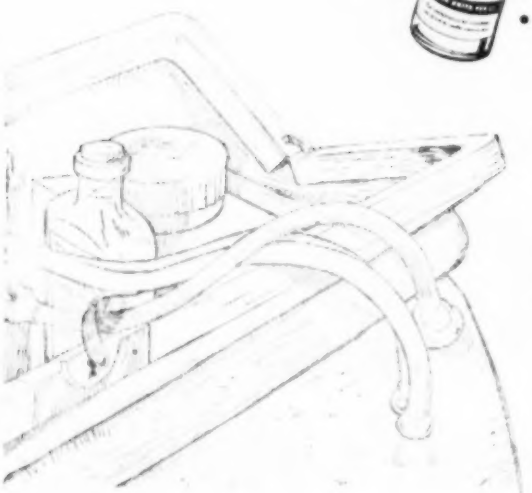

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SUCCESSFUL NON-SURGICAL TREATMENT OF ACUTE OSTEOMYELITIS OF THE ULNA

A CASE REPORT

JOSEPH B. HERMAN, B.Sc., M.B., CH.B. (CAPE)
Cape Town

It is well known now that antibiotics have completely changed the outlook in acute osteomyelitis.

The following report describes the course of a case of acute haematogenous osteomyelitis of the ulna treated with antibiotics without surgical intervention.

A. L., aged 20 months, was seen by me on 18 August 1952. His mother stated that he had been up crying all night and she had noticed that he was not using his right arm.

The patient had been seen previously on several occasions for exacerbations of acute infantile eczema from which he had been suffering since the age of 3 months.

Three weeks previously he had recovered from a pyrexial illness in which his temperature remained elevated up to 103° for 3 to 4 days. During this illness there were signs of skin infection—a boil on the chin and one on the left cheek with a good deal of surrounding cellulitis. On his left leg he had a superficial abscess which on incision, yielded about 1 ounce of thick yellow pus. Signs of left basal consolidation were present. During this illness the patient received injections of penicillin and sulphatriad by mouth for a few days. When the response to these did not appear satisfactory, aureomycin was given. He seemed well apart from some residual skin infection and was apyrexial during the 3 weeks following this illness.

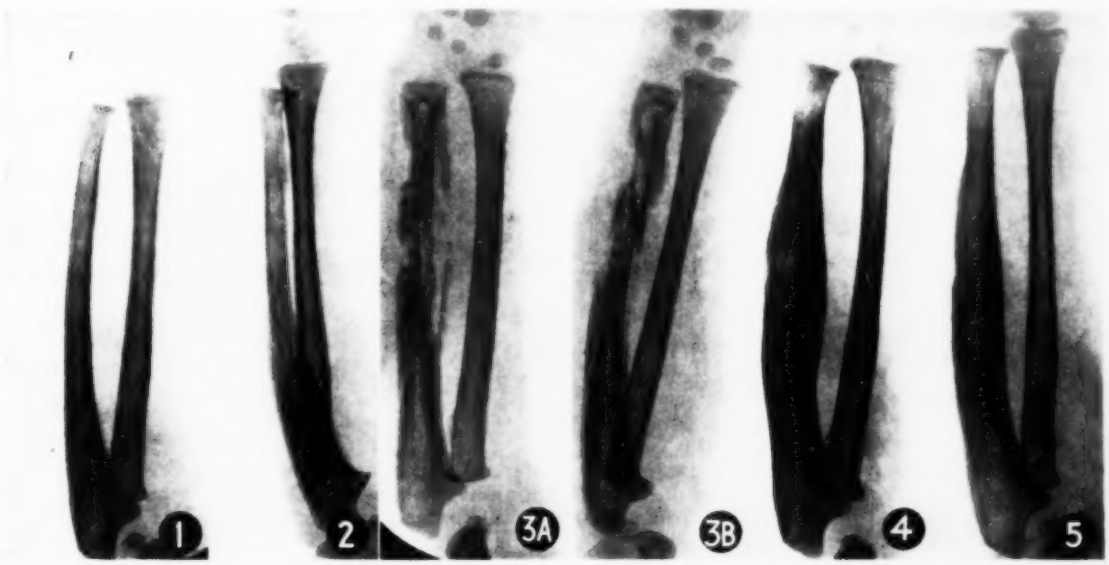
On 18 August the patient's temperature was elevated to 102°. Abnormal physical findings (apart from the infantile eczema) were limited to the right forearm and hand. The child resented movement of the right hand. The lower forearm and wrist were swollen and tender. Maximal tenderness was present over the lower part of the ulna. The clinical diagnosis was an acute osteomyelitis of the ulna.

PROGRESS AND TREATMENT

In view of the patient's poor response to penicillin in his previous illness, I decided to start immediate treatment with aureomycin in high dosage—250 mgm. 6-hourly was given.

On the 4th day the temperature was normal, and improvement in the patient's general condition was maintained throughout.

About 10 days after the onset of the illness, the forearm was immobilized in a plaster cast.



On 4 September 1952, i.e. 18 days after the onset, there was a rise of temperature to 103° which subsided the next day. Clinically there appeared to be no deterioration.

Aureomycin was stopped at this stage, and penicillin 500,000 units and streptomycin ½ to ¾ gm. daily were substituted for 7 days; after which aureomycin dosage was resumed and tapered off during the next 2 weeks.

THE RADIOLOGICAL COURSE OF THE DISEASE

Several X-rays taken during the course of the illness give the impression of radiological progression of the destruc-

tive lesion in the bone, but the clinical progress with ultimate healing was entirely satisfactory.

X-rays (Dr. K. Brauer): 23 August 1952 (Fig. 1). No evidence of bone infection can be detected.

2 September 1952 (Fig. 2). Gross bone infection is shown by the new bone formation extending the whole length of the shaft of the ulna.

25 September 1952 (Figs. 3a and 3b). The distal half of the ulna now shows complete destruction of the shaft with a large involucrum formed surrounding this bone, which is irregular in density and partially fragmented, particularly in its mid-portion. The periosteal reaction extends proximally the whole length of the ulna to the coronoid and olecranon processes.

30 December 1952 (Fig. 4). The gross thickening of the ulna throughout the greater length of the shaft is shown, but the bone appears to be fairly dense and the margin sclerosed. The appearances as a whole suggest than an almost complete healing of the osteitis of the ulna is present, the slight transradiant areas being of slightly suspicious nature, but even these are not necessarily definitely active at the moment.

4 June 1953 (Fig. 5). Some slight thickening of the middle of the ulna is shown, which is irregular in density. No evidence of active infective changes, periosteal change or other abnormality can be detected. The alignment of the forearm appears to be within normal limits.

Judged by clinical and radiological criteria, the disease can be divided into 4 phases:

1. Active disease of bone as judged by symptoms and signs; but no evidence of radiological abnormality (c.f. Fig. 1).

2. Radiological evidence of bone involvement (c.f. Fig. 2); clinically the process in the bone appears quiescent.

3. Radiological extension of the abnormal bone appearance (c.f. Figs. 3a and 3b); clinically the patient is much improved.

4. Radiological evidence of bone healing (c.f. Figs. 4 and 5).

The main point of this case report is well summarized by MacAdam [1] when he states, 'Early radiological changes are evidence of the degree of initial bone damage; later changes are part of a process of healing, and cannot be attributed to continuing infection.'

SUMMARY

This is a case report, with illustrative X-rays, of acute haematogenous osteomyelitis treated successfully with antibiotics without operation.

In the diagnosis and treatment of acute osteomyelitis clinical criteria are of primary importance. X-rays are valuable from the point of view of assessing progress or discovering complications in the illness.

I wish to thank the Radiologist, Dr. K. Brauer, for taking these X-rays.

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PULMONARY ADENOMATOSIS

CASE REPORT

H. L. HEIMANN, M.D., F.R.C.P.

and ERIC SAMUEL, M.D., F.R.C.S., D.M.R.E.

Johannesburg

Pulmonary adenomatosis is of special interest to the medical practitioner in South Africa in view of the remarkable resemblance between the clinical and pathological course in the human with a veterinary disease which occurs frequently in South African sheep, *jaagsiekte* (Cowdry [1]; Cowdry and Marsh [2]).

There has been no definite record of a direct transmission from sheep to humans but it interesting to note that the patient in the reported case was a farmer who on questioning admitted that he had several sick sheep on his farm but unfortunately the exact nature of the sickness had not been determined. No transmission of *jaagsiekte* to humans has been recorded nor is it claimed in this case.

This isolated case-report is presented to draw attention to the extensive radiological changes which may occur with comparatively little clinical disturbance. This feature is of some importance as the case reports recorded in the literature (Paul and Ritchie [3]) suggest that advanced radiological changes are associated with extensive clinical disturbances.

CASE REPORT

W. P., a male aged 60 years presented complaining of hoarseness of 4 days' duration. He had been prompted to seek advice because this was the second attack of the same symptom in a few months. Two weeks before investigation he had noticed some haemoptysis and still more recently a troublesome cough. Dr. M. Jackson, who first saw the patient, found on examination of the larynx a partial paresis of the left vocal cord, and the patient was referred for a general physical and radiological examination.

Physical examination (H. L. H.) revealed a well-nourished

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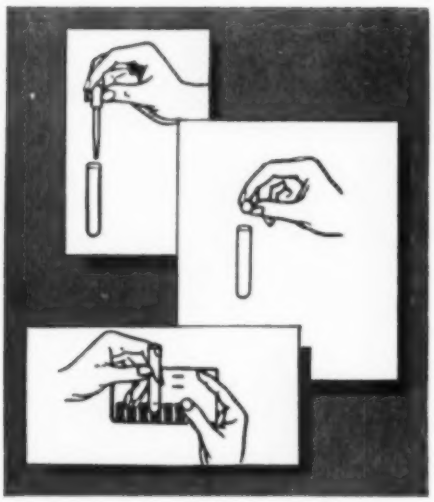

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adult male with good colour. There were no adventitious sounds in the chest although the breath sounds all over the chest were rather weak. No glands were palpable and the cardiovascular system was normal. The patient was referred for a radiological examination of the chest. This revealed a coarse patchy opacity diffusely scattered throughout both lung fields. The radiological interpretation offered was as follows:

'The differential diagnosis lies between:

(1) Collagen disease involving the lung fields.
(2) Pulmonary adenomatosis.
(3) Pulmonary sarcoidosis.
(4) Fungus disease.

'The presenting features are those of a relatively fit middle-aged man with extensive changes in the pulmonary fields. For this reason pulmonary adenomatosis or secondary deposits are unlikely.

'Likewise fungus disease is usually associated with considerable sputum and usually associated with a greater degree of constitutional disturbance.

'Pulmonary sarcoidosis frequently gives relatively extensive radiological changes without any marked constitutional disturbance. However, the symptom of hoarseness, which is this patient's main complaint, is extremely rare in pulmonary sarcoidosis.

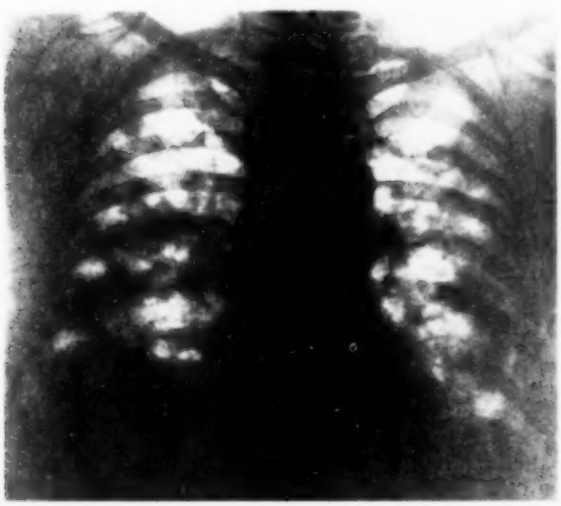

Fig. 1. Teleradiograph of the chest showing multiple patchy nodules present throughout the lung fields. There is an absence of pleural reaction and any enlargement of the hilar glands.

'It is of interest to note that the patient is a farmer who has noted that some of his sheep have suffered from sickness, and, in view of this, the possibility of the pulmonary manifestations being those of a pulmonary adenomatosis cannot be excluded. Pulmonary adenomatosis is endemic among the sheep in South Africa and goes under the name of *jaagsiekte*.

'Two other conditions which must be considered are those of a specific disease of the lung fields, i.e. (a) gummata and (b) multiple hydatid cysts. Multiple hydatid cysts are unlikely as the individual lesions are generally sharply defined and not associated with the degree of reaction around the individual gummata as seen in this case'.

In view of these findings, the patient was admitted to a nursing home for observation and whilst in the home the blood staining of the sputum and cough persisted.

Sputum examination for bacilli and fungus was negative and the Ide test and hydatid complement-fixation test were also negative.

Microscopic examination of the sputum (Dr. I. Webster) revealed malignant cells, but it was not possible to type them and none of the characteristic rosettes of cells (Hatfield and Hill [4]) were noted. He was seen in consultation with Mr. L. Fatti, who advised and performed a lung biopsy. Histological report (Dr. Webster) of the biopsy section was as follows:

'Sections taken from the biopsy specimen from the lung show the presence of an irregular sub-pleural nodule in which the alveoli are lined and in some instances packed with cuboidal cells. An occasional group of mucus-secreting cells are present.

'Although the alveolar walls are thickened, the elastic lamina and the reticular network appear to be intact.

'In the surrounding lung tissue there are a few alveolar emboli, some of which are associated with an inflammatory reaction. There is no connection, in the slides examined, between the bronchioles and the tumour nodule.

'The histological features are those of a nodule from a pulmonary adenomatosis or an alveolar cell carcinoma. On a biopsy specimen the origin of the tumour nodule from the bronchi or other bronchioli cannot be excluded, but the features are more suggestive of the above diagnosis.'

SUMMARY

1. A case of pulmonary adenomatosis is presented.
2. The possible relationship to *jaagsiekte* is considered.
3. The radiological features are discussed.
4. Emphasis is laid on the disproportion between the physical condition and the radiological findings in the case presented.

We are indebted to Dr. Webster of the South African Institute for Medical Research for the histological reports and to Mr Fatti for performing the bronchoscopy and biopsy. We are indebted to Dr. M. Jackson who first saw the case, for permission to publish the details of the laryngoscopic examination.

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4. Hatfield, W. H. and Hill, J. E. (1949): Amer. J. Rad. **62**, 525.

A CASE OF RETAINED URETHRAL CATHETER WITH FISTULA OF THE URETHRA

B. W. FRANKLIN BISHOP, F.R.C.S. (ED.)

Kimberley

The patient, a Coloured male aged 41, was admitted to Kimberley Hospital on 7 April 1953. In June 1952, while living in a small country town in the Southern Free State, he developed an attack of acute urinary retention. After attempts at catheterization by his local doctor he was transferred to a larger town where there was a hospital. By that time there were swellings in the perineum and the scrotum was swollen. A suprapubic cystostomy was performed and the swellings in the perineum and scrotum were incised. A Du Pezzer self-retaining catheter was inserted into the bladder. In August 1952 after the perineal and scrotal wounds had healed the bladder was apparently reopened and then a catheter was passed by the usual retrograde 'railroad' method. From that time apparently no urine flowed through the transurethral catheter. After some time, and as a result of some upset in the hospital, the patient returned home and remained there with the suprapubic drain, and the transurethral catheter still *in situ* but not draining. Eventually he was seen by another doctor who sent him to the Kimberley Hospital.

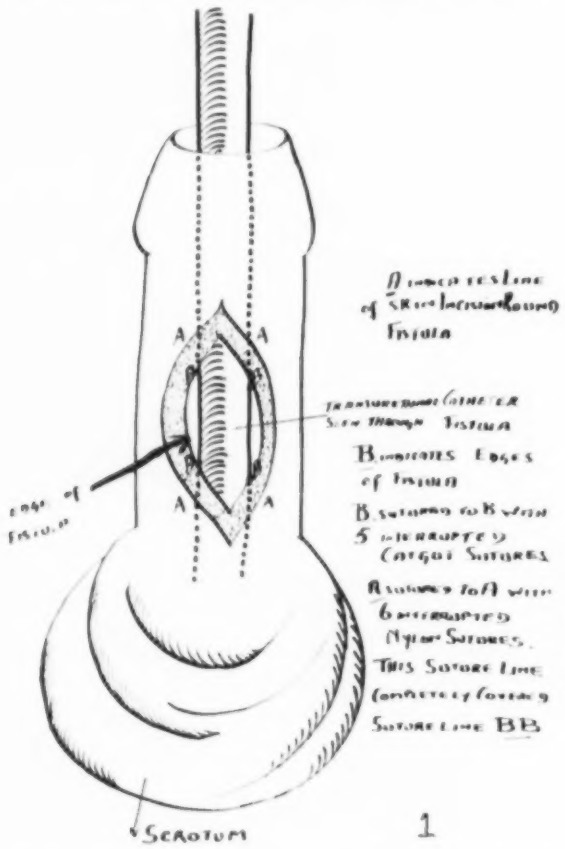
On admission he was found to be in fair general health.

The intravenous pyelogram and cystogram reports were as follows:

Intravenous Pyelogram: Both kidneys function normally, and show normal appearances. The right ureter shows kinking in its lower end. The left ureter shows slight dilatation of its lower end. The bladder shows very irregular filling and there is much irregularity of its outline. Cystography is suggested.

Cystogram: There is irregularity at the base of the bladder. The cause of this is not obvious radiographically.

The prostate on palpation was normal.



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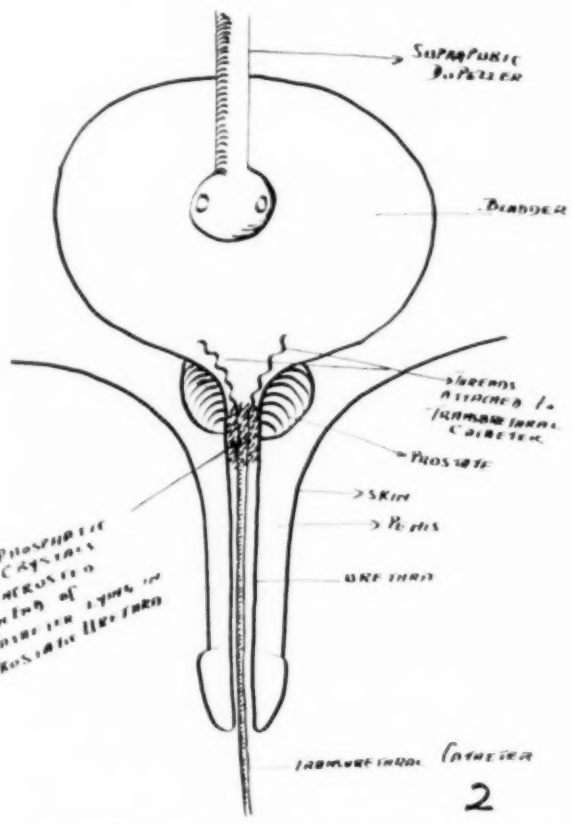

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The suprapubic catheter was draining turbid, purulent, evil-smelling urine. The suprapubic wound was satisfactory. The transurethral catheter could not be moved at all. There was no drainage whatsoever from it. There was a urethral fistula on the dorsum of the penis at the junction of the penis and skin of the scrotum. The fistula was

discharging thin purulent material. The transurethral catheter could be visualized in the floor of the fistula. The blood urea was satisfactory.

OPERATION

On 10 May 1953 the patient was taken to the theatre, and under gas and oxygen and Trilene the suprapubic wound was reopened and the bladder entered. This presented great difficulties as there was considerable fibrosis and scar tissue as the result of the two previous suprapubic operations. When the bladder was entered large quantities of foul turbid urine escaped. The Du Pezzer catheter was removed. Only one eyelet was partially open. The others were completely obstructed by phosphatic incrustation which was surrounding the terminal end of the catheter. The bladder was contracted, with very thickened mucosa heavily incrusted with phosphates. No calculi were discovered, and the transurethral catheter could not be felt in the bladder cavity, but eventually two pieces of thread were felt in the depths of the bladder. The free ends of these were delivered into the suprapubic wound and grasped with an artery forceps, and on pulling on them it was soon obvious that they were attached to the transurethral catheter. By further tractions the catheter was withdrawn into the bladder and out through the suprapubic wound. This catheter was heavily incrusted with phosphates, which was the reason why it could not be withdrawn through the external meatus. Also, the lumen was completely filled with phosphatic debris. Two pieces of thin silk, each about 2 in. long, were attached to the tip of the catheter.

A new Du Pezzer catheter was inserted into the bladder, which was then closed tightly round the Du Pezzer, a corrugated rubber drain was inserted into the retropubic space, and the suprapubic wound was closed in layers.

The second stage of the operation consisted of passing curved metal bougies per urethra. There was no difficulty in the passage of the largest bougie, though one could feel the slight bar of an old prostatic stricture.

Then the fistula of the urethra was closed in the following manner (see Figs. 1 and 2): An incision was made round the fistula about 2 mm. away from its edges. Then the inner edges were sutured together with interrupted fine atraumatic catgut sutures, the knot being tied external to the lumen of the urethra. The skin edges were brought together with fine nylon sutures. The wound was dressed with sterap powder and watertight dressings. No transurethral catheter was inserted.

Post-operational. The patient made an uninterrupted recovery. After 5 days he passed urine and the suprapubic Du Pezzer catheter was removed. The retropubic drain was removed 3 days later. The fistula wound healed well and the suprapubic wound was healed in 10 days. The patient was discharged from hospital in about 18 days from the operation.

COMMENT

The interest of this case lies in the fact that this patient existed with an obstructed transurethral catheter for from August 1952 until May 1953. This must have given him a great deal of discomfort, especially on sexual stimulation. Also, the catheter was never in the bladder and one can only imagine that the thread broke in the process of 'railroading'. The fistula of the urethra must have developed as a result of pressure-necrosis of the urethra by the indwelling catheter.

The last point of interest was how rapidly the sepsis cleared up on removal of the catheter, and the rapid healing of the suprapubic wound and the fistula.

MEDICO-LEGAL

TWO NAMES REMOVED FROM REGISTER

At its meeting held in Johannesburg on 23 September 1953, the full South African Medical and Dental Council heard an inquiry into the conduct of Dr. F. J. K. against whom the following charge was preferred:

That he is guilty of improper conduct or disgraceful conduct or conduct which when regard is had to his profession is improper or disgraceful in that:

He was convicted in the Supreme Court of South Africa (Witwatersrand Local Division) on 24 September 1952, of the crime of falsitas, in that during August 1943 and at Johannesburg, he did unlawfully, falsely and with intent to defraud, give out and pretend to the Board of a company that he, on their behalf had purchased from P. O. certain property situate in Vereeniging for £70.000 whereas in truth and in fact he, when he so gave out and pretended, well knew that P. O., when approached by W. Mc. D. M., acting as agent, asked £45.000 for the above-mentioned property, but was offered, and he accepted, £50,000, provided he signed a deed of sale for £70,000 and gave a receipt for the difference of £20.000, and thus, to the prejudice of the company in the sum of £25.000, he committed the crime of falsity; and that he was sentenced to imprisonment with hard labour for four years.

After having heard the evidence and having deliberated on the case the Council resolved that Dr. F. J. K. is guilty of disgraceful conduct and that his name be erased from the register of medical practitioners.

OFFENCES COMMITTED IN ENGLAND

The full Council also heard an inquiry into the conduct of Dr. C. L. B. against whom the following charge was preferred:

That he being a registered medical practitioner registered under the Medical, Dental and Pharmacy Act, 1928, is guilty of improper or disgraceful conduct when regard is had to his profession, in that he was at the Assizes held in Birmingham, England, on 9 July 1951, convicted on an indictment that he:

1. On 28 April 1951, at Birmingham with the intent to procure the miscarriage of a woman unlawfully used an instrument or some other unknown means;
2. Unlawfully administered a poison or other noxious thing;
3. Between 27 and 30 April 1951, with the intent to procure the miscarriage of the woman, unlawfully caused to be taken by her a poison or other noxious thing;
4. On 3 April 1951, with the intent to procure the miscarriage of another woman, unlawfully administered a poison or other noxious thing,

and he was ordered to be imprisoned for a period of 2 years on each count, the sentence to run concurrently.

The Council resolved that Dr. C. L. B. be found guilty of disgraceful conduct and that his name be erased from the medical register.

SUSPENDED FOR SIX MONTHS

At the same meeting Council considered the report of the Executive Committee in regard to an inquiry into the conduct of Dr. A. A. V. The Committee reported that it had held an inquiry into the conduct of Dr. A. A. V. at its meeting in May 1953, when the following charge which was preferred against him was considered:

That he is guilty of improper or disgraceful conduct or conduct which when regard is had to his profession is improper or disgraceful in that:

1. He was convicted in the Magistrate's court at Aliwal North on 7 August 1952, contravening Section 48 (1) (b) of Ordinance 15 of 1938 as amended, in that on or about 17 July 1952, he did wrongfully and unlawfully drive a motor car while under the influence of intoxicating liquor, and he was sentenced to a fine of £35 or alternatively to one month's imprisonment with hard labour and his licence was suspended for a period of six months.
2. He was convicted in the Magistrate's court at Aliwal North on 7 August 1952, of contravening Section 166 (i) (1) of Act 30 of 1928, read with Section 168 (1) (a) thereof, in that on or about 5 August 1952, in Steyn's Street, Aliwal North, he was wrongfully and unlawfully drunk, and he was sentenced to a fine of £2 or alternatively to one month's imprisonment with hard labour.

The Council resolved that Dr. A. A. V. be found guilty of disgraceful conduct and that he be suspended from practice as a medical practitioner for a period of 6 months.

The Council, realizing that Dr. A. A. V. would have to make arrangements in regard to the treatment of any patients at present under his care, decided that the suspension should come into operation with effect from 1 November 1953.

NEW PREPARATIONS AND APPLIANCES

NEW ORGANIC MERCURIAL DIURETIC

That ancient and honorable element, mercury, finds itself a constant aid to cardiac patients. Its chief value is in the form of organic compounds which act directly on renal tubules, depressing certain enzymatic activities. As a result, the reabsorption of chloride and sodium by the tubules is impaired.

Since retention of sodium and water (due to abnormally increased tubular reabsorption of sodium) is an important factor in the development of cardiac oedema, the organic mercurial compounds are potent diuretics. The mercurial diuretics are effective adjuncts to digitalis and other measures in the treatment of congestive heart failure. Dramatic improvement may be expected in most patients with peripheral oedema, congestion of the liver, ascites, pleural effusion, acute pulmonary congestion or oedema, or paroxysmal nocturnal dyspnoea. The nephrotic syndrome and hepatic cirrhosis with ascites also often respond to therapy with the newer diuretics, which are used not only to eliminate the accumulation of excessive fluid from the body but also to prevent the recurrence of oedema.

'Dicurin Procaine' (Merethoxylline Procaine with Theophylline, Lilly) is the newest of the organic mercurial diuretics. Several investigators have reported on their experiences with about 2,000 subcutaneous injections. Local reactions were infrequent and minimal and were not serious enough to limit the continuous use of the diuretic. It is safe, potent, and non-irritating compound and can be given intramuscularly or subcutaneously.

Method of Administration: The dosage of a mercurial diuretic and the frequency of injection should be guided by a weight record of the patient and close clinical observation. In the initial therapy of massive oedema, 'Dicurin Procaine' may be given in doses of 0.5 to 2 c.c. to produce a daily loss of body weight of 2–4 lb. (1 to 2 kg.). Once the oedema has disappeared and the body weight has reached a stable level ('dry weight'), the dose of the drug and the intervals between the injections should be adjusted to maintain the patient in the asymptomatic state of compensation. If feasible, mercurial diuretics are administered early in the morning in order to obtain diuresis predominantly during the day and to avoid disturbance of the patient's night rest. It is given by deep subcutaneous or intramuscular injection.

THE BENEVOLENT FUND

The following contributions to the Benevolent Fund during September 1953 are gratefully acknowledged:

Votive Cards: In Memory of:
Margaret, wife of Judge A. J. Smit *by* Dr. G. P. de Kock
Dr. Otto Hooper *by* Libertas Nursing Home and Drs. A. D. and B. Polonsky
Dr. David Cohen *by* Drs. A. D. and B. Polonsky
Mr. C. E. H. Green *by* Dr. C. A. H. Green
Total Amount Received from Votive Cards £11 11 0

Services Rendered to:
Mr. Terlien *by* Dr. A. A. Zabow
Mrs. Clegg *by* Drs. Pat and James Lynch
Dr. A. Rosin *by* Dr. B. Navid
Dr. J. H. Sypkens *by* Drs. Besselaar, M. Weinbren, Pen Wessels and J. Gluckman
Dr. D. A. van Binnendyk *by* Dr. Hamilton Bell
Mrs. A. Deolin *by* Dr. Hamilton Bell
Mrs. Cilliers, wife of Dr. E. J. Cilliers *by* Dr. B. D. Knoblach
Total Amount Received from Services Rendered £49 3 0

Donations:

Members of Cape Western Branch (Collection Box)	£6 11 9
West Rand Division of Southern Transvaal Branch	50 0 0
Estate late Dr. H. A. Moffat	100 0 0
Dr. P. H. Kampfraath	12 0
Total	£217 17 9

PASSING EVENTS

SAINT VINCENT PRIZE FOR MEDICAL SCIENCES

The Academy of Medicine of Turin, Italy, announces a competition for the first 'Saint Vincent Prize for Medical Sciences' of 7,500,000 lire, founded for the promotion of scientific research in the medical field. The conditions are as follows:

The prize will be given for an essay or essays, printed, dealing with a single medical subject representing some noteworthy progress in knowledge resulting from research which must have been published since 1950, and 5 copies must be sent by registered post to the Academy of Medicine in Turin (Via Po, 18) and must be delivered not later than 31 December 1953. They must be in Italian, Latin, French, English, Spanish, Portuguese, German or Russian. Competitors are requested to enclose also a summary in Italian or French. The winner will be announced at a meeting to be held in Italy on a date to be determined in June 1954.

INTERNATIONAL EXHIBITION, TURIN

Sponsored by the *Minerva Medica* Journalistic Group of the Italian Medical Association, the Second International Medical and Health Exhibition will be held in the Valentino Park, Turin, Italy, from 29 May to 6 June 1954. The display will illustrate recent progress in medical surgery and hygiene.

At the same time international meetings will be held—medical, pharmaceutical and veterinary—and also the Second International Medico-Scientific Film Festival.

Similar exhibitions and conventions which were held in Turin in 1951 were attended by a large concourse of medical men from many countries.

For information application should be made to the Minerva Medica Office, Corso Bramante 83, Turin, Italy.

UNION OF SOUTH AFRICA: DEPARTMENT OF HEALTH

BULLETIN NO. 39 OF 1953, FOR THE 7 DAYS ENDED THURSDAY 24 SEPTEMBER 1953

PLAGUE

Cape Province. One (1) Coloured death at Brandvlei in the Calvinia district. Diagnosis confirmed by laboratory tests. All necessary precautionary measures are being taken.

Precautionary Measures against Plague. The public is urged to report any abnormal rodent mortality which comes to their notice, immediately to the local magistrate or nearest police station.

The application of D.D.T. is the most effective precautionary measure against fleas, which convey plague from rodents to human beings. All floors, burrows, holes and crevices, etc., as well as bedding and clothing, where fleas are suspected to be present should be thoroughly dusted with 10% D.D.T. in talc, at the rate of approximately half a pound per room. Any person required to work in a place where he may be exposed to infected fleas, is advised to wear gumboots and overalls and to dust the inside of the gumboots with D.D.T. If overalls or gumboots are not available, socks should be pulled over trousers at ankles. Measures should at the same time be taken to destroy rodents by gassing, poisoning or trapping. The ordinary cyanogas pump may also be used for dusting burrows and other inaccessible places with D.D.T. powder.

SMALLPOX

Nil.

TYPHUS FEVER

Cape Province. One (1) Native case in the Gxulu location in the Keiskamahoek district.

One (1) Native case in the East London Municipal area.

One (1) Native case in the Queenstown Municipal area.

The above-mentioned 3 cases have all been confirmed by laboratory tests.

EPIDEMIC DISEASES IN OTHER COUNTRIES

At date of latest available information there existed:

Plague in Phanthiet (Viet-Nam).

Cholera in Bombay, Calcutta, Madras, Visakhapatnam (India); Dacca (Pakistan).

Smallpox in Bombay, Calcutta, Cochin, Kanpur, Madras, Nagapatinam (India); Saigon-Cholon (Viet-Nam).

Typhus Fever: Nil.

HYPERCHLORHYDRIA

A drug, known as epoxytropine tropate methylbromide, has recently been developed which reduces the excretion of hydrochloric acid in the gastric juice. In tests on laboratory animals only small doses of the drug are needed to reduce acid secretion by half. The drug has also been tested on human beings and has produced only relatively mild side-effects. This drug may obviously have a use in the treatment of peptic ulcer.

DE-CAFFEINATED COFFEE

The Minister of Health under the Foods, Drugs and Disinfectants Act 1929 has promulgated amended regulations which define de-caffeinated coffee as coffee from which a large portion of caffein has been removed. It may not contain more than 0.1% of caffein, and must be labelled 'De-Caffeinated Coffee' in type of prescribed size.

WHO EXPERTS DISCUSS POLIOMYELITIS AND MALARIA

The first session of the WHO Expert Committee on Poliomyelitis took place in Rome on 14–19 September 1953. It was attended by members from 7 countries (Canada, France, Great Britain, Israel, South Africa, Sweden and the United States of America). The South African member was Dr. J. H. S. Gear, Deputy Director, South African Institute for Medical Research.

A recently published WHO statistical survey has shown the disease to be 'a threat of world-wide significance', and this has led to the calling of this Expert Committee. The Committee had under consideration:

The need for international research into the various types of the poliomyelitis virus and their characteristics, the aim being to devise procedures which would facilitate research in any country where it was needed.

Geographical distribution, both during epidemic periods and at other times, and the influence of climate, environment, and social and economic factors.

The various clinical manifestations of infection with poliomyelitis virus, including symptomless and mild cases.

The portals of entry and exit of the virus, distribution within the body, factors predisposing to, or precipitating, paralysis, and immunity and the age when it is acquired.

Practical control measures to reduce both the spread of infection and the incidence of paralysis.

Immunization, including the effect of gamma-globulin.

At present 'poliomyelitis can neither be prevented nor cured'.*

* Press Release WHO/41.

MALARIA

The WHO Expert Committee on Malaria held its Fifth Session in Istanbul (Turkey), on 7–14 September 1953. It was attended by members from 7 countries (Belgian Congo, Brazil, Ceylon, France, Great Britain, Greece, Pakistan). Among the matters considered were the following:

The systematic spraying of 'residual' insecticides like DDT on the inside walls of dwellings, which has, acording to a series of reports, been incontestably established as an inexpensive and successful method of destroying the vector mosquito. This method has for many years been practised in the Native territories of South Africa, especially in Zululand and the Transvaal, with excellent results. The Committee had under consideration various questions under this heading; e.g. quantities of insecticide required according to climate, the vector, and the nature of the walls sprayed; and resistance, which, though rarely, may be developed by certain species of anopheles.

Other methods of malaria control, e.g. in Borneo jungle areas it is reported that the breeding of the vectors has been reduced by 95% by making clearings around the water-collections ('letting in the sun').

Anti-malarial drugs.

LOCAL HEALTH SERVICES

A WHO Committee of Experts met in Geneva (Switzerland) on 21–25 September 1953 to consider steps necessary for the planning of an integrated health programme for local areas. It was attended by public-health administrators and professors from 7 countries (Finland, France, Great Britain, Indonesia, Mexico, Nigeria and the United States of America).

Among the items discussed were the need for organized community effort, the problem of national resources and needs in personnel and supplies, and 'international partnership' in planning and carrying out of programmes.

INDUSTRIAL HEALTH

WHO, in co-operation with ILO and the Italian Government, held a seminar on occupational health at Milan, Italy, from 28 September to 3 October 1953. It was attended by 60 participants from 12 countries of Europe and North Africa. The course consisted of lectures, discussions and demonstrations.

There were 8 lecturers from Italy, France, Belgium and Great Britain. The proceedings were in French. At a similar course held last year at Leyden in the Netherlands they were in English.

OPENING OF SANTA'S SETTLEMENT AT UITENHAGE

The Orsmond Tuberculosis Settlement at Uitenhage, Eastern Province, will be officially opened by the Minister of Health, Dr. van Rhyn, on 24 October 1953. Members of Welfare organizations and all Associations affiliated to SANTA have been invited to attend the ceremony.

The Settlement which has been named after Dr. E. Orsmond, Chairman of SANTA Uitenhage Branch, and Medical Officer of Health for the Municipality already has 70 patients receiving treatment. The patients are both Coloured and Native and they range from infants in cots to an oldest inhabitant of 80 years.

A unique feature of the Settlement is the little chapel where patients can worship and receive spiritual comfort and help in the cure of their disease.

The staff consists of a European Warden, who is an ex-tuberculosis patient and a Matron, Miss Lambert.

The local residents of Uitenhage have been most generous and it is largely through their efforts that this new venture is such a great success.

FIRST ALUMNI DINNER

Under the auspices of the University of the Witwatersrand Medical Graduates Association the first alumni dinner at which the guests will be the class of 1924 and their teachers and present members of staff, has been arranged for Thursday, 29 October 1953, at the Automobile Club, Killarney, Johannesburg.

REVIEWS OF BOOKS

INTENSIVE PSYCHOTHERAPY

Principles of Intensive Psychotherapy. By Frieda Fromm-Reichmann, M.D. (Pp. 246 + xviii. 18s.) London: George Allen & Unwin Limited. South African representatives: Howard B. Timmins, Cape Town. 1953.

Contents: *Part I*. The Psychiatrist: Personal and Professional Requirements. 1. Insight into the Emotional Aspects of the Doctor-Patient Relationship. 2. The Psychiatrist's Part in the Doctor-Patient Relationship. 3. The Psychiatrist's Attitude toward Cultural and Ethical Values in its Relatedness to the Goals of Psychotherapy. 4. Considerations of the Psychiatrist in the Establishment of the Treatment Situation.
Part II. The Psychotherapeutic Process: The Patient and the Therapist. 5. The Initial Interview. 6. Introductory Remarks on the Psychotherapeutic Procedure. 7. Associations, Marginal Thoughts, Physical Sensations, and Their Usage in Psychotherapy. 8. Interpretation and its Application. 9. How to Begin and How to Terminate a Psychotherapeutic Interview. 10. Termination of Treatment.
Part III. Adjuncts to Intensive Psychotherapy. 11. The Attitude of the Psychiatrist toward Intercurrent Events in the Lives of the Patient and of the Therapist. 12. Contacts with Relatives. Reference List. Index.

Though one need not fully subscribe to all the principles enunciated in this tome, it is well worth reading. Though the book is addressed to psycho-analysts or students of psycho-analysis, the material contains a great amount of information for students of psychiatry, especially with respect to the handling of patients and the practitioner's state of mind and attitudes.

The author is not a pure Freudian, and has deviated from the Freudian theories to a great extent.

The literature index is very useful indeed for those interested.

TEXTBOOK OF PREVENTIVE MEDICINE

Textbook of Preventive Medicine. By Hugh Rodman Leavell, M.D., Dr.P.H. and E. Gurney Clark, M.D., Dr.P.H. (Pp. 629 + xviii. $8.00.) New York: Toronto; London: McGraw-Hill International Corporation. 1953.

Contents: 1. What is Preventive Medicine? 2. Levels of Application of Preventive Medicine. 3. An Epidemiologic Approach to Preventive Medicine. 4. The Prevention of Infectious Diseases. 5. Nutrition in Preventive Medicine. 6. Long-term Illness and the Effect of the Aging Process on Health. 7. The Prevention of Cancer. 8. Preventive Medicine in Certain Other Fields. 9. Heredity and Preventive Medicine. 10. Maternal and Child Health. 11. Mental Health. 12. Occupational Health. 13. Health Screening. 14. Preventive Services in Medical Practice. 15. Rehabilitation as a Phase of Preventive Medicine. 16. The Doctor and his Community. 17. Provisions for Meeting Basic Needs in the Community. 18. Biostatistics. Index.

This book, as the authors state in their introduction, is directed primarily towards the development of a point of view, a philosophy, and a method of approach to health promotion and disease prevention. The statistics and manner of such approach have been devised for particular application to the United States of America.

All aspects of the socio-economic, epidemiological, and preventive facets are presented, and the lesson derived from a study of the 600 pages of this book is that the clinician, no matter what his specialty might be, is in the happy position, providing he is prepared to mould his thoughts to the epidemiological approach of presenting to his students very much more than the signs of diseases and their diagnosis.

Many of the social and medical problems presented and their solution by the epidemiological approach are those with which we in this country are finding ourselves increasingly faced. The communicable diseases as such, do not claim their victims with the same dramatic swiftness to-day as previously, and the accent is now shifting to the problems of the ageing process and the control and prevention of chronic diseases which follow in its wake. This chapter on rehabilitation and that on genetics and its relationship to preventive medicine are two of the best in this publication and will well repay close and intensive study.

One small inaccuracy regarding primary liver carcinoma in the Bantu in this country as the cause of the greatest number of deaths from malignancy has crept in and should be amended in subsequent editions.

The book is well printed, the type clear, the paper of excellent quality, and the bibliography at the end full and detailed. One of the happiest features, and one that could be recommended to many other authors, is the list of additional reading recommended at the end of each chapter.

Although this publication is designed primarily for undergraduates its study by general practitioners and specialists alike would do much to broaden their outlook on the present-day needs and trend of medicine, and assist them in that 'better doctoring' which is our main aim as a profession.

YEAR BOOK OF NEUROLOGY, PSYCHIATRY AND NEUROSURGERY

The 1952 Year Book of Neurology, Psychiatry and Neurosurgery. Edited by Roland P. MacKay, Nolan D. C. Lewis, and Percival Bailey. (Pp. 603 with 121 figures. $6.00) Chicago: The Year Book Publishers, Inc. 1953.

Contents: *Neurology*. 1. Introduction. 2. Anatomy. 3. Physiology. 4. Pathology. 5. Trauma. 6. Infectious Diseases. 7. Vascular Disturbances. 8. Degenerative Diseases. 9. The Epilepsies. 10. Cranial and Spinal Nerves. 11. Diagnostic and Therapeutic Methods. *Psychiatry*. 12. Introduction. 13. General Topics. 14. Child Psychiatry. 15. Schizophrenia, Affective Disorders and Miscellaneous Reactions. 16. Organic Disorders and Toxic Reactions. 17. Therapy. *Neurosurgery*. 18. Introduction. 19. Intracranial Tumors. 20. Intraspinal Tumors. 21. Tumors of Peripheral Nerves. 22. Hemorrhagic Lesions. 23. Vascular Lesions. 24. Anesthesia. 25. Trauma. 26. Pain. 27. Infections. 28. Radiation. 29. Intervertebral Disks. 30. Malformations. 31. Motor Disturbances. 32. Psychosurgery. 33. Miscellaneous.

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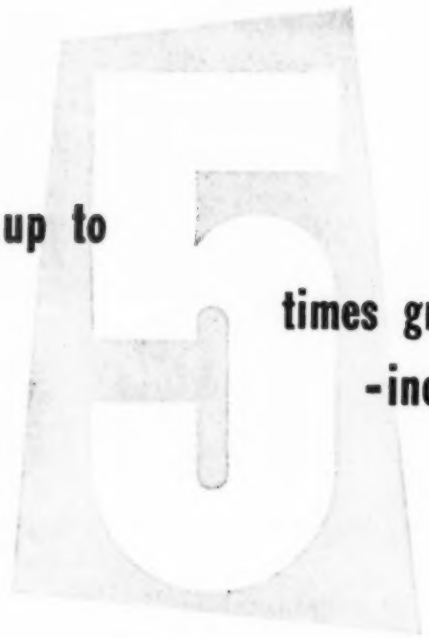

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with excellent illustrations. This year the section on Neurosurgery has been re-introduced, and this step will be commended by all interested in neurology and neurological surgery, as differentiation does help to separate two fields which, in the opinion of most, can never completely overlap.

Dr. Bailey in his introduction makes some interesting comments on the status of Russian neurosurgery and medical propaganda, but his jibe at the National Hospital, Queen's Square, London, as not having advanced beyond the stage of having to 'call in' surgeons to operate no longer holds any sting, for a fully organized surgical department has existed at that hospital for some years.

Dr. MacKay draws attention to the changing fields of interest in Neurology, which now lie in physiological mechanisms and on the borders of psychology rather than in the domain of diseases and treatment. For instance, he points out that neurosyphylis, which formerly would occupy a considerable section of any neurological compendium, now only achieves one or two articles a year in the *Year Book*.

The section on Psychiatry fights clear of psychoanalytical material and for this many readers may be thankful, for analytical articles do not summarize easily and space can be given to more cogent and concrete matters. Psychosurgery, psychosomatic medicine, and pharmacological interactions are the bridge between psychiatry and neurology, and a glance at former Year Books show an increasing emphasis on the organic in this section.

Once again the *Year Book*, both in form and material, achieves the standard we have learned to expect of it, and once more it proves its indispensability.

NEW CLASSIFICATION OF TUBERCULOSIS

The Classification of Pulmonary Tuberculosis. By Milosh Sekulich, M.D. (Pp. 322. 63s.) London: Wm. Heinemann Medical Books Limited. 1953.

Contents: 1. Foreword. 2. Acknowledgements. 3. Introduction: A Brief Summary of the Processes Involved in the Law of Evolution and Involution. 4. Planning of Long-Term Management. 5. The Outlook for the Future.
Part I: The Suggested Classification and its Basis. 6. Historical Survey. 7. The Suggested Classification. 8. Diagram. 9. Table of the Terms Used in the Present Classification. 10. The Pathological, Pathogenetic, Clinical, Radiological, Prognostic and Therapeutic Considerations on which the Present Classification is Based.
Part II: Personal Series Illustrating Suggested Classification. 11. Description of the Four Groups of Forms of Pulmonary Tuberculosis. I. Inflammatory Forms. II. Caseous Forms. III. Fibro-Caseous Forms. IV. Fibrous Forms. 12. Complications of Pulmonary Tuberculosis. 13. Some Aspects of the Morbid Anatomy of Pulmonary Tuberculosis Based on the Study of Operation Specimens and the Present Classification. 14. The Pathogenesis of Fibrous Forms. 15. The Present Classification. 16. Table of the Terms Used in the Present Classification. 17. Definitions. 18. Standard Terms. 19. Application of the Present Classification. 20. Statistical Punched Cards. 21. Summary. Appendices. Bibliography and References.

Systems of classification of pulmonary tuberculosis are notoriously unsatisfactory and this causes difficulty in compiling statistics and also in evaluating the results of other workers. In this interesting and highly informative volume Sekulich sets out to review and criticize early and present-day systems and to propose a new one which is based on a study of the pathology of the disease from the viewpoint of what he terms 'the law of evolution and involution'. By this he means that the progress of a tuberculous lesion is governed by well-defined laws, and that regression proceeds in a direction in which each step is the reverse of that seen in the progressive stage. For this reason the study of progressing and also of regressing disease affords valuable help in classifying lesions and providing a standard which the author believes might well become of international use. The thesis is well defended and the matter is admirably set out. Fifty-four cases are described and classified, 158 plates, which are mostly reproductions of skiagrams, are used in illustration and each figure is carefully annotated.

It is not possible to say if this system will find international approval, but it is worth studying, and physicians should be able to test its value by applying the principles, which are by no means complicated, to the cases of patients under their care.

CLINICAL SURGERY

An Approach to Clinical Surgery. By Gerald H. C. Ovens, *O.B.E.*, M.B., B.S. (Lond.), F.R.C.S. (Eng.). (Pp. 309 + vii, with 118 illustrations. 22s. 6d.) London: J. & A. Churchill, Limited. 1953.

Contents: 1. Introduction.
Part I. General Principles. 2. Sterilization. 3. Inflammation. 4. Wounds. 5. Haemorrhage. 6. Shock. 7. Infection. 8. Operations. 9. Dressings.
Part II. History-taking and Examination. 10. General Scheme for all Cases. 11. Tumours and Swellings in General. 12. Diseases of the Abdomen: A. The Acute Abdomen. B. The Chronic Abdomen. 13. Diseases of the Anus and Rectum. 14. Diseases of the Urinary System. 15. Inguino-scrotal Swellings. 16. Ulcers. 17. Diseases of the Tongue. 18. Diseases of the Lymphatic Glands. 19. Diseases of the Breast. 20. Acute Injuries of the Head. 21. Fractures. 22. Diseases of Bones. 23. Diseases and Injuries of Joints. 24. Peripheral Vascular Disease. Appendices I, II and III. Index.

There are many books which either give or profess to give an introduction to Clinical Surgery. The term itself is used differently by various authors and at first sight one can see little point in new books on this subject. The present book does, however, have several particular virtues.

Although written in very simple language the book holds one's attention. There is a rather delightful old-fashioned tendency to make very dogmatic statements and produce certain aphorisms, although the author does not call them that. Unlike many of the older works this book succeeds in giving very simple explanations for a number of clinical signs. It also contains certain comments on a number of subjects not usually covered in works of this nature or in the usual surgical textbooks.

Mr. Ovens is Professor of Surgery in the University College of the West Indies and the present short monograph obviously serves as a manual for his students. They are certainly fortunate in having it available.

SULPHONAMIDES AND ANTIBIOTICS

The Sulphonamides and Antibiotics in Man and Animals. By J. Stewart Lawrence, M.D. (Ed.), M.R.C.P., John Francis, M.Sc., M.R.C.V.S., with the assistance of Arnold Sorsby, M.D., F.R.C.S. and Philip G. Scott, F.R.C.S. (Pp. 482 + xi, with 39 illustrations. 42s.) London: H. K. Lewis & Co. Ltd. 1953.

Contents: Prefaces. 1. Introduction. 2. Mode of Action. 3. Drug-Resistance. 4. The Sulphonamides: Chemistry and Bacteriology. 5. The Sulphonamides: Pharmacology and Choice of Compound. 6. The Sulphonamides: General Considerations. 7. The Sulphones, Thiosemicarbazones and p-Aminosalicylic Acid. 9. Penicillin. 10. Streptomycin and Neomycin. 11. Chloromycetin. 12. Aureomycin and Terramycin. 13. Streptococcal Infections. 14. Staphylococcal Infections. 15. The Pneumococcus. 16. The Neisseriae. 17. The Enteric Bacteria. 18. The Mycobacteria. 19. The Spirochaetal Infections. 20. Miscellaneous Bacterial Infections. 21. Rickettsial and Virus Diseases. 22. Regional Infections. 23. Diseases of the Eye. 24. Diseases of the Ear, Nose and Throat. 25. Diseases of the Skin. 26. Traumatic Surgery. 27. Sulphonamides and the Antibiotics in Prophylaxis. 28. Veterinary Medicine: Pharmacology and Antibacterial Potency. 29. Veterinary Medicine: Therapy. 30. Other Uses of the Antibiotics and Sulphonamides. 31. Laboratory Tests. Appendix. References. Index.

The practitioner nowadays finds that a good deal of his practice consists in prescribing antibacterial agents. So many have become available that it is important to know which are the best for particular infections. The book here reviewed can be thoroughly recommended for its readable, balanced, accurate and well-documented accounts of the sulphonamides and the antibiotics, which will be of everyday practical value to those administering these drugs.

The important question of whether antagonism rather than synergism occurs with combined antibacterial drugs is considered; there are certain indications for combined therapy, which is otherwise better avoided. Drug-resistance, of such practical importance in chronic infections and in prolonged prophylaxis, is discussed. This is important also in relation to the spread of resistant organisms from patient to patient or from carriers (among the medical or nursing staff) to the patient. In surgical wards penicillin-resistant strains are found in patients who have been in hospital some time; modern therapeutic agents cannot take the place of meticulous surgical care.

Sulphonamides, especially sulphadiazine, are still drugs of choice for meningococcal infections. Although combined

sulphonamides have been used to diminish the danger of crystalluria, such mixtures have recently been shown not necessarily to provide additive effects. The sulphonamides are contra-indicated in lupus erythematosus. There is evidence that the course of acute tonsillitis is not affected by sulphonamides.

The proper use of penicillin in subacute bacterial endocarditis is indicated; aureomycin is not satisfactory as a routine. Fatal reactions to penicillin occurring especially after repeated courses of therapy have been described; interesting is the suggestion that procaine penicillin crystals allowed to get into the circulation may possibly produce nervous symptoms. A febrile reaction following penicillin therapy of gonorrhoea may indicate a possible concurrent syphilitic infection.

In deciding on a suitable drug the predominant organism is not necessarily the aetiological agent. The *in vivo* testing of antibacterial compounds is important (research workers note) as *in vitro* testing can only give a rough indication of *in vivo* potency.

This book has great practical value.

Pneumothorax Techniques

The Principles of Thoracic Anaesthesia Past and Present. By William W. Mushin, M.A., M.B., B.S., M.R.C.S., F.F.A.R.C.S., D.A. and L. Rendell-Baker, M.B., B.S., M.R.C.S., D.A. (Pp. 172 + vii, with 193 figures. 42s.) Oxford: Blackwell Scientific Publications. 1953.

Contents: Preface. Illustrations. Introduction. *Part I.* The Pneumothorax Problem and its Solution. 1. The Problem. 2. Solutions of the Problem. 3. Controlled Respiration. 4. Closure of the Chest Wall. *Part II.* Historical Background. 5. Resuscitation. 6. The Beginnings of Intubation. 7. Early Chest Anaesthesia. 8. The Positive Pressure Period. 9. Insufflation. 10. Early Automatic Devices for Rhythmic Inflation. *Part III.* Methods in Use To-day. 11. Modern Automatic Devices for Rhythmic Inflation. 12. The Development of Tracheal and Bronchial Intubation and of the Control of Secretions. 13. Anaesthetic Agents. Conclusion. Appendices. Biographical Notes. Index.

The authors, in their preface, state frankly that theirs is not a 'how-to-do-it' book. It deals chronologically with the numerous techniques devised in the past to overcome the formidable problem of an open pneumothorax. These techniques have now been superseded by the modern method of apnoea and manual inflation, or automatic mechanical inflation.

The book is the result of extensive research through a vast literature, and brings to light matters not generally known, and is full of useful information. There is something in its pages to please and instruct everybody. Even the oldest anaesthetist—a pioneer himself—will find it most interesting. But for the younger men it is essential to become acquainted with its contents. By getting to know the evolutionary process of the past, they will be able to do research along new lines, and will avoid the errors of their predecessors.

The book is written in an easy style, is profusely illustrated, and printed on excellent paper. It has a comprehensive index and a bibliography at the end of each chapter. It is assured of a lasting place in the medical literature.

Poliomyelitis

Poliomyelitis. By W. Ritchie Russell. (Pp. 84 + vi, with 20 figures. 14s.) London: Edward Arnold & Company. 1952.

Contents: 1. Nature of the Disease. 2. Clinical Features of the Disease. 3. Physical Examination. 4. Factors which Influence Cell Vulnerability. 5. Management and Treatment. 6. The Development of Paralysis. 7. Respirator Treatment. 8. Care of Muscles and Joints. 9. The Rate of Rehabilitation. 10. Future Prospects. References. Index.

The author draws attention to an important aspect of the treatment of poliomyelitis when, in his preface, he points out that this disease is treated by a variety of specialists.

This monograph gives an intelligent and balanced survey of the topical approach to the problems of poliomyelitis. Major and minor illness phases are discussed in relation to physical activity and an attempt is made to evaluate the resultant degree of paralysis.

Several types of respirator are described and criteria for their indications and contra-indications are clearly set out. Methods of rehabilitation are outlined and the author makes a plea for early and vigorous activity by means of carefully graded exercises.

This is a short but excellent book for all who have to deal with this widespread and disabling disease.

Knowledge of Tuberculosis

The White Plague : Tuberculosis, Man and Society. By René and Jean Dubos. (Pp. 277 + x. 15s.) London: Victor Gollancz Limited. 1953.

Contents: *Part I.* The White Plague in the Nineteenth Century. 1. The Captain of All the Men of Death. 2. Death Warrant for Keats. 3. Flight from the North Winds. 4. Contagion and Heredity. 5. Consumption and the Romantic Age.
Part II. The Causes of Tuberculosis. 6. Phthisis, Consumption and Tubercles. 7. Percussion, Auscultation and the Unitarian Theory of Phthisis. 8. The Germ Theory of Tuberculosis. 9. Infection and Disease.
Part III. Cure and Prevention of Tuberculosis. 10. The Evaluation of Therapeutic Procedures. 11. Treatment and Natural Resistance. 12. Drugs, Vaccines and Public Health Measures. 13. Healthy Living and Sanatoria.
Part IV. Tuberculosis and Society. 14. The Evolution of Epidemics. 15. Tuberculosis and Industrial Civilization. 16. Tuberculosis and Social Technology. Appendices. Bibliography and Notes. Index.

The White Plague is a most comprehensive compilation of current and historical fact and opinion, which has been built up with consummate skill from material provided by an extremely extensive bibliography.

The authors maintain throughout a strictly scientific subjectivism, yet present their facts and the often conflicting views of recognized authorities in so lucid a manner that the reader's obvious conclusions can with confidence be accepted as representing the consensus of present-day world opinion.

Part I, although it contains a wealth of highly interesting historical gossip, might perhaps have been curtailed.

Parts II to IV are consistently excellent, though considerably more could have been made of the psychological and psychosomatic aspects of aetiology and prognosis by an author of the outstanding ability of Dr. Dubos.

Part IV, dealing with the social aspects of tuberculosis, has been so skilfully presented that it will be found eminently readable even by the most cynical of general practitioners, to whom literature on this subject is usually as mildly interesting as a curate's sermon on brothels to a prison congregation.

Although 'The White Plague' is not intended, and cannot serve, as a text-book, it contains a wealth of reliable information and will give all but the already expert a very clear picture of the present state of knowledge of tuberculosis. From this exposition general practitioners particularly will derive a far greater facility in understanding and judging the value of other and more technical writings.

The book is extremely well written, makes pleasant and entertaining reading, and should find favour amongst a very wide public.

Cancer in General Practice

Basic Principles of Cancer Practice. By Anderson Nettleship, M.D., F.C.A.P. (Pp. 398 + xii with 106 illustrations. 54s.) London: Baillière, Tindall and Cox. 1953.

Contents: 1. Introduction. 2. The Status of Present Day Cancer Practice. Clinical Behaviour of Neoplasms. 3. Methods of Cancer Diagnosis. 4. The Clinical Pathology of Neoplasms. 5. Local and Systemic Effects of Cancer. 6. Treatment of Cancer. 7. Neoplasms of Children. 8. Neoplasms of the Skin. 9. Neoplasms of the Gastro-intestinal Tract, Liver and Pancreas. 10. Neoplasms of the Breast. 11. Neoplasms of the Female Genital System. 12. Neoplasms of the Male Genito-urinary System, Kidney, Bladder and Prostate. 13. Neoplasms of Blood Forming Organs. 14. Neoplasms of the Lung, Nasopharynx, Larynx, Trachea and Bronchi. 15. Neoplasms of Bone, Muscle and Connective Tissue. 16. Neoplasms of the Central Nervous System. 17. Neoplasms of the Endocrine Organs. 18. How Cancer Research Affects Clinical Cancer Practice. A Review of the Biochemistry of Cancer. 19. Relation of Occupation and Trauma to Cancer. Medico-Legal Aspects of Oncology. Oncology and General Practice. The Future of Oncology. Index.

This book has the sub-title 'On Diagnosis, Prognosis and Treatment of Human Neoplasms for the General Practitioner and Medical Student'. The author justifies it by stating that much of the progress in the last 20 years has been published

in specialist journals, and is unavailable to the general practitioner. Those views are open to argument, but whether one agrees with them or not, it cannot be said that this book supplies that need.

We cannot recommend it to general practitioners, who will rightly resent the platitudes and admonitions, and will reject some of the advice, such as the instructions for aspiration biopsy. 'The usual method is to take an 18 or 16 gauge needle and small syringe and, after wetting the apparatus to make it air tight, the needle is passed into the tumour and positive pressure put on the plunger'. Nor can it be recommended to medical students, as the following extracts from the chapter on neoplasms of children indicate (reviewer's italics): 'Occasionally childhood tumours are discovered by medical accident. . . . They usually originate in some developmental defect or embryonic flaw; this should not immediately damn them as teratomata-monsters, *and therefore hopeless*. . . . There is the long gap between fifteen years and the fifth decade *in which very few tumours occur*. . . . The laboratory procedures employed may point to *specific neoplastic alterations such as anaemia and high white blood cell count*. . . . Wilm's tumour or embryoma as it is more properly termed, has a history of bad behaviour.'

By comparison, the grammatical errors, misuse of words, and the very curious adjectives and adverbs employed seem of little moment. The author in his preface states that 'The tremendous chance to try and improve the practising physician's early diagnosis of cancer by writing this book seems inescapable.' We cannot help feeling however that though the book has been written the chance has indeed escaped.

CORRESPONDENCE

BANTU SYPHILIS

To the Editor: It is agreed that the serological tests for syphilis are fallible, but my disagreement with Drs. Sachs and Selesnick is on their attitude to the disease syphilis. While we should not rely implicitly on serological tests for diagnosis and the assessment of therapy, I feel most strongly that the importance of the disease should not be minimized because the 'Signpost to syphilis . . . the serological test' is fallible.

I am certain that the authors would not regard tuberculosis as a minor problem because one of its practical signposts, 'cough' is not necessarily diagnostic of tuberculosis.

Drs. Sachs and Selesnick hold the view that the large-scale investigation of possible syphilitics is not practical. Services are provided to X-ray chests and examine sputa to find tuberculosis (for which disease there are unfortunately not enough treatment centres). On the same basis we can undertake clinical studies, screen the aorta and conduct cerebrospinal fluid examinations, where necessary, to find syphilis—a preventable disease which can be treated while the patients are ambulatory.

I would add that screening and cerebrospinal-fluid examinations would not cost the country more than X-ray films and sputum examinations.

The authors (19 September) 'are surprised at this low figure' of 1,085 Bantu deaths certified due to syphilis in the Union in 1947, but they gloss over the next sentence, 'As the majority of Bantu deaths are not certified the annual figure must be much higher'.

Drs. Sachs and Selesnick should remember that this figure is below the true death rate, that there is an appreciable non-fatal morbidity from syphilis, and that syphilis is a communicable disease.

Might I ask what the authors would do if one of their friends or servants had a positive serological test for syphilis? Would they ignore the probability of syphilis while they searched for better tests?

Incomplete or selected statistics can be used to substantiate opposing points of view. The arguments Drs. Sachs and Selesnick have presented for the innocent nature of syphilis are based on serological figures and *selected* statistics of 4 cases in 3 centres in 1948.

I suggest that they use Union-wide figures or at least give the picture from centres with greater mortality rates. In addition, they should compare the mortality rates for syphilis with those for other diseases. As an example, in Johannesburg in 1948 (the year for which they quote) the following were the deaths among 413,531 Africans from syphilis and some other important diseases.[1]

Cause of Death	*Number of Deaths*
Tuberculosis, Pulmonary	668
Tuberculosis, other forms	174
Diphtheria	38
Syphilis, all forms	295
Poliomyelitis	33
Rheumatic Fever	11

With due deference to the authors' remark (19 September), 'The difficulty of statistical evaluations is that it requires almost as much statistical knowledge to interpret as to assess the figures', it is quite evident that syphilis still bulks largely as a public-health problem.

Drs. Sachs and Selesnick have not proved 'that seropositivity does not reflect the presence of syphilis' in most cases. In spite of their sweeping statement that Brusgaard's figures are incorrect, they are more in accordance with the facts of morbidity and mortality due to syphilis than are the authors' serological generalizations.

Drs. Sachs and Selesnick have not produced any evidence either in their original paper (1 August) or their letter (19 September) to justify their dangerous suggestion that the vote for venereal disease should be reduced in favour of grants for research into specific tests for syphilis. On the contrary, there is more than enough evidence of the effects of syphilis on the Bantu (or any other) population to warrant an increased and sustained therapeutic programme to eradicate the disease.

I. J. Grek.

Coronation Hospital,
Coronationville,
Johannesburg.

REFERENCE

1. M.O.H. Johannesburg: Personal Communication.

GASTRO-OESOPHAGEAL REGURGITATION

To the Editor: I have read with considerable interest the article *Gastro-oesophageal Regurgitation* by Werbeloff and Merskey[13] in your *Journal* of 29 August 1953, and I fully endorse the letter written to you by Dr. N. A. Lawler[10] on 9 September 1953.

The conclusion reached by the authors seems to me to disregard their own findings. They conclude that the history of epigastric or substernal pain related to posture is a feature in cases of sliding hiatus hernia. No less than 11 of their patients complained of epigastric or substernal pain related to posture but in only 3 of them were they able to demonstrate the presence of a hernia.

We have only very rarely found reflux in normal subjects and Donnelly[5] in his recent study of the subject found it 'essential first of all to determine the factors normally preventing regurgitation and herniation in a healthy subject'. Yet Werbeloff and Merskey found 9 symptomless cases of reflux in 200 examinations; so it seems to me that the only possible explanation is that they are using a definition of the term which differs from ours and from Johnstone's.[7, 8] We use the word to mean free and repeated regurgitation of gastric contents to the cricoid sphincter. We are firmly of the opinion after more than 4 years' clinical and radiological study that patients with the symptoms described by us (Lawler and McCreath[11]) will exhibit such regurgitation if the correct technique is used. The production of the pain appears to us to require firstly, an active, powerfully working oesophagus, and secondly, a sufficient quantity of regurgitated gastric contents. We would not expect symptoms and have

not found symptoms in cases showing a mere trickle of reflux, and the only cases of massive, symptomless reflux that we have observed have been in patients in whom the oesophagus lay inert, making no endeavour to rid itself of its contents. Perhaps the reflux observed by Werbeloff and Merskey was not always free or massive and perhaps in some cases the oesophagus was inactive.

From the clinical aspect I should like to stress that unless a clinician is fully aware of the syndrome, the history he takes will be found to omit important symptoms. Complaints of heartburn, acid regurgitation, or a lump in the throat, tend to be disregarded as insignificant. I have found many serious omissions in my own case-records written before I was aware of the importance of these symptoms. Histories taken from hospital records are, so far as this syndrome is concerned, likely to be highly misleading. Mr. Norman Tanner (personal communication) considers history-taking in dyspepsia, and particularly in the syndrome under discussion, to be much more difficult than is generally realized.

That reflux is the one constant finding in patients with the characteristic symptoms is shown by the following observations:

1. Herniation alone without reflux does not produce the characteristic symptoms. Moersch[12] reported 19 cases of herniation in 246 symptom-free patients. Brick and Amory[4] found 4 cases of hiatus hernia in 300 patients without significant gastro-intestinal symptoms. They did not screen the patients in the forward-bend position or the figure would no doubt be higher. We have many times confirmed this observation in the course of well over 3,000 barium-meal examinations.

2. The symptoms are present when free and repeated reflux is the only finding, i.e. without herniation. We have demonstrated this using the silver clip technique described by Allison[1] and Johnstone.[9]

3. The results of operative tightening of the hiatus with reduction of the hernia depend entirely, in our experience, on whether or not reflux continues. If it does continue the symptoms persist unchanged. If reflux has ceased the symptoms are relieved.

4. Fifty per cent of the patients with symptoms which we ascribe to reflux complain at times of acid regurgitation into the mouth, the bitter fluid frequently containing particles of food. At these times the stomach contents have escaped the grip of the cricoid sphincter. It is only when the sphincter bars the progress of the ascending fluid and the oesophagus endeavours to return it that the typical pain is produced.

The frequency of this complaint of acid regurgitation indicates to us that reflux of gastric contents is the essential factor in the production of symptoms.

It is important to realize that reflux oesophagitis or even oesophageal ulceration may occasionally cause only very mild symptoms, just as peptic ulcers may perforate (14%) or bleed (16%) without preceding dyspeptic symptoms (Ivy *et al.*[6]). The patient may present as a case of anaemia, caused by continued slight haemorrhage from the oesophagus, or the inflammatory process may go quitely on to stricture formation. I would suggest therefore that reflux as observed by Werbeloff and Merskey cannot be considered to be benign in the absence of the findings on oesophagoscopy.

Finally I should like to say that although *reflux oesophagitis* (Barrett[3]) is an admirable term which 'describes accurately in two words the pathology and aetiology of a condition which is a common cause of digestive disorder' (Allison and Johnstone[2]), we have found oesophagitis in only 33% of all cases of reflux, though it is to be emphasized that all patients complained of the characteristic symptoms.

We believe, therefore, that the syndrome should be named *reflux dyspepsia*, oesophagitis, oesophageal ulceration (excluding Barrett's ulcer) and stricture formation being regarded as complications.

N. D. McCreath, M.B., M.R.C.P., M.R.A.C.P.
'Halstow,'
22 St. George's Road,
Bickley, Kent,
England.
28 September 1953.

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An Operation 'Free of Charge'

To the Editor: I advised Tonsillectomy for a child seen in Witbank. The mother, a resident of Pretoria, telephoned me remarking that it would be quite convenient for her to have the operation done in Witbank, as she would be visiting there shortly, provided that it would be free of charge.

She said she could have it done free of charge in Pretoria at the General. The case is not one which is classifiable as a 'Hospital Case'. The mother stated that they paid very heavy taxes and liked to 'get something' for it.

Having briefly explained that Hospital staff was for the provision of medical services to those who could not afford them I was told in a polite voice—that could only belong to a heavy tax payer—that the operation would be done in Pretoria.

It is quite easy, I was told. 'All you do is get a note from your doctor and in you go; lots of people do it.'

The guilty G.P.'s should take note and change their ways. One feels too that here is a sound reason for introducing a little screening process into the hospital concerned—and elsewhere.

Allan Davis.

Witbank.
29 September 1953.

General Practitioners' Fees

To the Editor: It seems that if general practitioners are to survive under the present economic conditions they will have to raise their fees substantially. The following are, in short, the reasons why general practitioners should raise their fees.

Prices of food, clothing, houses and general services have been doubled and trebled since 1939. Doctors' fees, on the other hand, have been raised by only 25%, and in the case of workmen injured on duty by 7½%.

General practitioners get no cost-of-living allowance, whereas hundreds of thousands of their patients draw substantial cost-of-living allowances. Doctors must subscribe to these cost-of-living allowances through increased taxation and higher prices for commodities and services.

The prices of motor cars, which are essential for general practitioners, have increased three times their pre-war cost, while garage services appear to be equally high. Petrol and oil and motor car spares have also increased substantially in price. Rent of premises for a surgery is about twice as high as it was in 1939. The cost of practising as a general practitioner has been doubled and trebled.

Surely, if general practitioners are to be able to carry on their practices and to be able to support their wives and children, they need to increase their fees proportionately to the increased cost of general practice and of living.

Would it be unreasonable for general practitioners to raise the fee for a consultation to £1 1s. and for a visit to £1 11s. 6d.?

F. A. Lomax.

91 Cross Street,
Kroonstad.
4 October 1953.

PRANTAL-*RA* TABLETS

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NEW CONVENIENCE FOR THE PEPTIC ULCER PATIENT

Each **PRANTAL-*RA*** Tablet contains a total of 100 mg. PRANTAL Methylsulphate.

Outer layer rapidly provides initial 50 mg. dose.

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WHAT IS ROTERCHOLON?

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Powerfully stimulates secretion and flow of bile. Hinders formation of gall-stones, improves biliary drainage which relieves spasticity. Stimulates gastric function and intestinal peristalsis. Has mild antiseptic action, which favourably influences inflammation of biliary passages.

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KAAPSTAD : CAPE TOWN

Posbus 643, Telefoon 2-6177: P.O. Box 643, Telephone 2-6177

PRAKTYKE TE KOOP : PRACTICES FOR SALE

(1356) Very well established CAPE TOWN SUBURBAN PRACTICE. Outright sale or alternatively partnership share available to Gentile purchaser. Excellent opportunity to acquire a good class practice. Details on application.

(1387) Boland. Nucleus praktyk en goeie voorraad instrumente, ens. teen £400. Uitstekende vooruitsigte vir uitbreiding.

(1437) Prescribing practice in Transkei 90% native and therefore cash. Gross takings over £2,000 p.a. including contract of approximately £150 p.a. Little night or week-end work, definite scope for expansion. No surgery and little maternity done. Easy travelling distance from sea. Surgery for hire at £5 p.m. Owner going overseas and therefore prepared to sacrifice at £600 for quick sale.

(1459) KAAPSTAD—SUIDELIKE VOORSTAD. Vennootskapsaandeel in goedgevestigde algemene praktyk met uitstekende spoorwegaanstelling. Goeie toekoms vir Afrikaanse geneesheer met ondervinding. Gerieflike huis te huur. Verder besonderhede op aanvraag.

(1457) Goed gevestigde Westelike Provinsie praktyk. Netto inkomste oorskry £3,000 per jaar. Huis beskikbaar. Verband kan gereël word. Volle besonderhede op aanvraag.

ASSISTENTE/PLAASVERVANGERS VERLANG ASSISTANTS/LOCUMS REQUIRED

(1475) Boland. Plaasvervanger vir maand November verlang. £2 12s. 6d. per dag plus losies en kartoelae.

PLAASVERVANGERS DRINGEND BENODIG

Vir stedelike en plattelandse gebiede vir die maande DESEMBER en JANUARIE. Volle besonderhede op aanvraag.

ROOMS TO LET

(1476) Cape Town. Waiting room and examination room available on long lease in St. George's Street building, Cape Town. Furniture for sale at £260. Excellent opportunity to acquire first-class rooms. (Quote also 1422.)

* * * *

JOHANNESBURG

Medical House, 5 Esselen Street, Telephone 44-9134-5, 44-0817
Mediese Huis, Esselenstraat 5. Telefone 44-9134-5, 44-0817

PARTNERSHIPS OFFERED : VENNOOTSKAPPE AANGEBIED

(P/O21) Half-share in essentially English-speaking private practice in Johannesburg. Gentile with 3 to 4 years' experience. Premium £2,500.

(P/O22) Reef hospital town. Half-share in a very well-established practice. Income 1953 was £8,300, mostly cash. Practice is 50% European-prescribing and 50% non-European dispensing and prescribing. Well-organized practice and very little night work. Preferably Jewish doctor.

(P/O24) Randse hospitaaldorp. Premie £1,500 en terme kan gereël word. Dit is 'n goedgevestigde praktyk en alleen persone met *ondervinding in chirurgie* sal in aanmerking geneem word, vandaar die lae premie.

(P/O25) Transvaal hospital town. Jewish partner is required. Well-established practice with an average annual income of over £5,000. All surgical facilities. Premium required is £2,000 and easy terms could be arranged.

PRAKTYKE TE KOOP : PRACTICES FOR SALE

(Pr/S82) Excellent non-European practice near Johannesburg. Established in 1944. Average annual *net* income £2,700 cash. Premium required is £2,000 and terms can be arranged. Premium includes contents of surgery and maternity ward.

(Pr/S78) Oud-gevestigde Vrystaatse praktyk met D.G. aanstelling. Gemiddelde jaarlikse inkomste oorskrei £4,000. Premie van £2,000, sluit medisyne en apparate in. Uitstekende geleentheid vir 'n jong man.

(Pr/S84) Pleasant town in Northern Transvaal, with hospital facilities. General practice which was run by seller for 10 years besides a large non-transferable mine appointment. The appointment did not allow time for any Native work—only for very few district calls. Net cash income over £1,200 per year though only few hours daily were spent in this practice. Premium £500 on terms. Excellent start for young man.

(Pr/S85) Progressive Transvaal dispensing practice. Excellent surgical facilities. Average gross income £3,500 per annum. Premium required £2,500 and the following terms could be arranged: £1,250 deposit and the balance over a period of 18 months, starting 3 months after cash payment. The premium includes drugs, furniture and fittings, estimated at £800. Two transferable appointments worth £230 per annum. Scope for expansion.

(Pr/S87) Wes-Transvaal. Uitstekende praktyk. Gemiddelde jaarlikse inkomste oorskrei £3,000. Woonhuis en spreekkamers te koop of te huur teen £14 en £11 per maand, onderskeidelik. Premie verlang is £1,500 en terme kan gereël word. Skryf om volle besonderhede.

(Pr/S88) O.V.S. Algemene praktyk met D.G. aanstelling. Geen opposisie. Jaarlikse inkomste ongeveer £3,500. Premie van £1,750 sluit in groot voorraad medisyne, instrumente en meubels. Hierdie is ook 'n ougevestigde praktyk.

(Pr/S90) Transvaal. Uitstekende praktyk in hospitaaldorp. Twee aanstellings. Inkomste oorskry £5,000. Ideale praktyk vir 2 geneeshere. Premie verlang is £2,500 en sluit medisyne, voorraad en instrumente in.

FOR SALE

(I/O54) Second-hand Beck Lee photographic cardiograph in good order. What offers?

ROOMS TO LET

Johannesburg. Consulting room and waiting room to share with general practitioner, in medical block, centre city. Fully furnished.

* * * *

DURBAN

112 Medical Centre, Field Street. Telephone 2-4049

PRACTICES FOR SALE : PRAKTYKE TE KOOP.

(PD15) General practice established 1941 at pleasant residential and seaside resort about 10 miles south of Durban. Annual income approximately £1,000. No major surgery, minimum of minor surgery and only emergency midwifery being done at present. Brick house with consulting room attached, for sale at £5,250. Owing to ill health owner wishes to retire from practice as soon as possible. Premium £1,000 including drugs, surgery and dispensary furniture.

(PD20) Natal South Coast. General mixed prescribing practice. Premium £1,000 plus £200 for full equipment of 2 surgeries. Large proportion of the patients are European visitors, and Indians. A lucrative Native practice could be built up if dispensing was carried out. Immediate introduction.

(PD21) East Griqualand. General mixed practice with net profit of £3,000 annually. Premium £1,900, terms if required. Excellent opportunity for newly qualified practitioner.

(PD22) Natal. Prescribing and dispensing country practice. Total gross receipts for 1951, £3,344 15s. 9d.; 1952, £2,817 10s. 6d.; 1953 (3 months), £846 6s. 10d. Premium £1,500, includes drugs, consulting room furniture and instruments. House for sale £5,500.

(PD23) Natal. Prescribing practice particularly suitable for a woman doctor interested in obstetrics and gynaecology. Total gross receipts for 1950, £1,570; 1951, £1,595; 1952 (6 months), £1,340; 1953 (3 months), £382. Premium £1,250, includes furniture, fittings, instruments, drugs and existing book debts.

(PD24) Natal South Coast. Practice suitable for doctor who does not want full time work. £250 for drugs, dressings, instruments, etc. No charge for goodwill. Small house on ½ morgen, £1,600. Immediate occupation.

PARTNER REQUIRED

(PDX) Durban. General practitioner offers 45% partnership on 18 months' purchase. Applicants should be experienced and be able to put down a certain amount of capital

Siekefonds van die Suid-Afrikaanse Spoorweë en Hawens

AANSTELLING VAN SPOORWEGDOKTER: DANVILLE (PRETORIA)

Aansoeke word van geregistreerde mediese praktisyns ingewag vir aanstelling in die betrekking van spoorwegdokter, Danville, d.i. Danville, Proklamasieheuwel, Iscordorp, gedeelte van Pretoria-Wes, wes van Potgieterstraat tot by Schuttestraat, Cordelfos, Voortrekkerhoogte en die spoorwegtrajek Pretoria (uitsluitend) tot by Magaliesburg (uitsluitend), teen 'n salaris van £797 per jaar, plus die gelde en toelaes wat in die Regulasies van die Siekefonds voorgeskryf word, en met die reg om privaat te praktiseer.

Die salaris is onderhewig aan wysiging in ooreenstemming met die sensus van lede wat op 1 April van elke jaar afgeneem moet word.

Die aanstelling geskied kragtens die regulasies van die Siekefonds, en opsegging van dienste is onderworpe aan vier maande kennisgewing deur een van beide partye.

Die suksesvolle applikant moet in Pretoria woon, dienste op 'n datum wat gereël sal word aanvaar en sy pligte ooreenkomstig die regulasies van die Siekefonds uitvoer.

Aansoeke moet die Distriksekretaris, Oos-Transvaalse Distriksiekefondsraad, Scheidingstraat, Pretoria, nie later nie as 7 November 1953 bereik, en applikante moet die volgende vermeld:

1. Volle naam.
2. Kwalifikasies (waar en wanneer verkry).
3. Ondervinding (waar en wanneer verkry en opgedoen).
4. Datum van geboorte.
5. Land van geboorte.
6. Getroud of ongetroud.
7. Of ten volle tweetalig.
8. Of Suid-Afrikaanse burger.
9. Watter staatsbetrekking, indien enige, beklee word.

Werwing deur of ten behoewe van enige applikant stel so 'n applikant bloot aan diskwalifikasie.

Enige verder besonderhede wat verlang word, kan op aanvraag van die Distriksekretaris by bovermelde adres verkry word.

P. J. Klem
Hoofsekretaris

Johannesburg
17 Oktober 1953

Cecil John Adams Memorial Trust

TRAVELLING FELLOWSHIPS

Mr. A. E. Adams has established a Trust for the endowment of Travelling Fellowships in memory of his son Cecil John Adams who lost his life in the last war.

A Fellowship is of the annual value of about £500 and shall be tenable for one complete year of twelve months, but may be extended for a further period at the discretion of the Selection Committee. Five Fellowships are available.

Candidates must be South African graduates in Medicine or Medical Science, they must have shown promise of being likely to profit from further study, research and experience in other countries and must have been resident in South Africa for at least three years immediately prior to the date of application for a Fellowship.

Application (in triplicate) must be made on a prescribed form obtainable from the undersigned, and must reach the Trustee by 7 November 1953.

J. J. le Roux
Trustee

The South African Association
6 Church Square
Cape Town

Assistant Required

Assistant with a view to partnership required as soon as possible for a partnership practice in the Peninsula. Write 'A. S. T.', P.O. Box 643, Cape Town.

South African Railways and Harbours Sick Fund

APPOINTMENT OF SALARIED PHYSICIAN SPECIALIST: DURBAN AND PIETERMARITZBURG

Applications are invited from registered specialists for appointment to the following positions at the salaries indicated, plus the fees and allowances prescribed in the regulations of the Sick Fund, and with the right of private practice:

Physician Specialist, Durban: £1,581 per annum.
Physician Specialist, Pietermaritzburg: £849 per annum.

The salaries will be subject to adjustment in accordance with the census of members to be taken on 1 April of each year.

The appointments will be made in terms of the regulations of the Fund, and will be subject to termination on four months' notice being given by either side.

The successful applicants will be required to reside in the centres concerned, to take up the appointments on dates to be arranged, and to carry out their duties in accordance with the regulations of the Fund.

Applications should reach the District Secretary, Natal District Sick Fund Board, Belgrave Mansions, Smith Street, Durban, not later than 31 October 1953 and should state:

1. Full name
2. Qualifications (when and where obtained)
3. Experience (when and where obtained)
4. Date of birth
5. Country of birth
6. Whether married or sing'e
7. Whether fully bilingual
8. Whether South African citizen
9. What Government appointment, if any, is held

Canvassing by or on behalf of any applicant is liable to disqualify such applicant.

Any further particulars may be obtained from the District Secretary, on application.

G. Freeling
Acting General Secretary

Johannesburg
3 October 1953

(Before submitting applications, practitioners are advised to communicate with the Hon. Secretaries, Natal Coastal and Natal Inland Branches (M.A.S.A.), 112 Medical Centre, Field Street, Durban and P.O. Box 285, Pietermaritzburg, respectively.—*Assistant Secretary, M.A.S.A.*)

Basutoland Government

VACANCY FOR MEDICAL OFFICER

Applications are invited from registered medical practitioners for the above pensionable post, on a salary scale of £865: £865 : £935 × 35—£1,005 × 45—£1,140 × 45—£1,320. Entry point on this scale is determined by war service and/or previous experience. Cost-of-living allowance is payable; the present rates are:

Married Officers: On the first £800 of salary—12½%, on the remaining salary—7½% with a maximum of £132 per annum.

Single Officers: One half of the above rates, subject to a maximum of £66 per annum.

Rental deduction of 10% of salary for furnished quarters.

Annual vacation (accumulative) leave of 6 weeks and 2 weeks occasional (non-accumulative) leave are granted, subject to the exigencies of the Service. Biennial warrant to the coast. Overseas leave passage allowance for officer, wife and proportionate allowance for children every tour of 3 years.

Private practice is at present allowed but it is subordinate to official duties.

A knowledge of practical surgery will be an advantage.

The climate is healthy and the Territory free from tropical diseases.

Applications should be forwarded to the Director of Medical Services, Maseru (from whom further particulars may be obtained) by 31 October 1953. (2470)

Assistent Benodig

Jong geneesheer benodig as assistent in gevestigde praktyk te Brits. Goeie vooruitsigte. Rig aansoeke aan ‚Dokter', Posbus 2, Brits, Transvaal.

Vacant District Surgeoncies

Applications for the undermentioned District Surgeoncies accompanied by full particulars as to date and country of birth, qualifications, experience and previous and present appointments of the applicants and the earliest date on which they can assume duty, if appointed, should reach the Secretary for Health, P.O. Box 386, Pretoria, not later than 28 October 1953. Testimonials (copies) may be submitted, but the Minister of Health wishes to be known that any candidate will be regarded as disqualified who directly or indirectly canvasses for appointment.

The appointments are on a part-time basis and private practice is not precluded.

Applicants should state whether they have a knowledge of both official languages, also whether they are competent to diagnose leprosy and venereal diseases and to use the modern intravenous and other therapeutic technique in the treatment of venereal disease. Applicants should also state whether they have any experience as a medical officer of health or in any similar capacity. If more than one post is applied for a separate application should be submitted in respect of each.

Place	*Salary per annum*	*Drug allowance per annum*
Cape Province:	£	£
Brandvlei	250	30
Carnarvon	265	60
Engcobo	305	15
Noupoort	120	20
Rhodes	350	25
Ugie	180	20
Villiersdorp	90	20
Transvaal:		
Bethal	360	75
Maandagshoek	500	50
Orange Free State:		
Boshof	435	50
Paul Roux	280	30
Reitz	450	90

The salaries cover all ordinary and routine services but travelling allowance of 1s. per mile for all mileage travelled outside a radius of three miles from headquarters, night detention at 15s. and supplementary fees for certain other services will be payable. Also fees for attendance at courts and inquests in accordance with the tariff of the Department of Justice.

Forms of application and copy of draft agreement will be furnished on application. (42660)

Municipality of Gwelo

MEDICAL OFFICER OF HEALTH

PART-TIME

Applications are hereby invited from suitably qualified persons, for the position of part-time Medical Officer of Health to the Municipality of Gwelo.

The holding of the Diploma in Public Health will be a recommendation.

The salary is £900 per annum plus £120 per annum transport allowance.

The successful applicant, who will be required to commence duties on 1 January 1954, will be allowed to conduct his own private practice on the understanding that his work as Medical Officer of Health must have preference except in cases of emergency.

The duties will include the supervision of the European Infectious Diseases Hospital and the African Clinic, and medical inspections of Natives.

Applications will be received by the undersigned until 16 November 1953.

R. R. Gregory
Town Clerk

Municipal Offices
Gwelo
2 October 1953

Vennootskap Verlang

Algemene praktisyn met ses jaar ondervinding in die Karoo, soek vennootskap in enige Bolandse dorp. Besit eie praktyk, en is bereid om te ruil vir 'n vennooskap in die Boland. Skryf aan „A. S. N.", Posbus, 643, Kaapstad.

Provincial Administration of the Cape of Good Hope

HOSPITALS DEPARTMENT

HOSPITAL BOARD SERVICE : VACANCY SHARLEY CRIBB NURSING COLLEGE, PORT ELIZABETH: LECTURES TO STUDENT NURSES

Applications are invited from registered medical practitioners to lecture student nurses at the Sharley Cribb Nursing College, Port Elizabeth, in the following subject, period ending 30 November 1954:

Materia medica—(English Lectures)—12 lectures per course—3 courses per annum.

Lectures are to be given between the hours 8 a.m. and 3 p.m. daily, each lecture to be of one hour's duration.

Lecturer will be remunerated at the rate of £1 1s. per lecture.

Further particulars will be obtained from the Principal, Sharley Cribb Nursing College, Park Drive, Port Elizabeth.

Application must be made on the prescribed form (Staff 23) which is obtainable from the Director of Hospital Services, P.O. Box 2060, Cape Town, or from the Medical Superintendent of any Provincial Hospital or from the Secretary of any School Board in the Cape Province.

Applications should be addressed to the Director of Hospital Services, P.O. Box 2060, Cape Town, and must reach him not later than 12 November 1953.

(A562767)

Provinsiale Administrasie van die Kaap die Goeie Hoop

HOSPITAALDEPARTEMENT

HOSPITAALRAADSDIENS : VAKATURE SHARLEY CRIBB-VERPLEGINGSKOLLEGE, PORT ELIZABETH: LESINGS VIR LEERLINGVERPLEEGSTERS

Aansoeke word ingewag van geregistreerde geneeshere om lesings aan Leerlingverpleegsters aan die Sharley Cribb-verplegingskollege, Port Elizabeth, te gee oor die volgende onderwerp vir die tydperk eindigende 30 November 1954:

Artsenykunde (Engelse Lesings)—12 lesings per kursus—3 kursusse per jaar.

Lesings moet gegee word tussen die ure 8 vm. en 3 nm. daagliks. Elke lesing sal een uur duur.

Lektor sal besoldig word teen £1 1s. per lesing.

Nadere besonderhede is verkrygbaar by die Prinsipale, Sharley Cribb-verplegingskollege, Park Drive, Port Elizabeth.

Aansoek moet gedoen word op die voorgeskrewe vorm (Staf 23) wat verkrygbaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige provinsiale hospitaal of by die Sekretaris van enige Skoolraad in die Kaapprovinsie.

Aansoeke moet aan die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, gerig word, en moet hom nie later as 12 November 1953 bereik nie.

(A562767)

Praktyk te koop

Verminderde premie. Noord Natal. Geen opposisie. Bruto inkomste £3,500 sluit in D.G. aanstelling en groot naturelle kontant inkomste. Premie van £1,000 sluit medisyne, instrumente en meubels in. 'n Woonhuis met 9 vertrekke en spreekkamers met 7 vertrekke, eie ligte installasie en waterpomp vir £3,000. Totaal £4,000. Verkoop om gesondheidsredes. Kontant verkies maar voorstelle tot terme sal oorweeg word. Skryf aan „A. S. Q.", Posbus 643, Kaapstad.

Assistant Wanted

Assistant wanted with view to partnership in general practice in Southern Rhodesia. At least 3 to 5 years' experience. Salary £100 per month plus car expenses. Afrikaans an advantage. Write "A. S. R.", P.O. Box 643, Cape Town.

Provincial Administration of the Cape of Good Hope

HONORARY MEDICAL APPOINTMENTS

Applications are invited from registered medical practitioners who are under the age of sixty years for appointment to the under-mentioned posts at the Rondebosch and Mowbray Hospital, Rosebank.

Number of Posts	*Designation*
1	Honorary Anaesthetist.
2	.. Assistant Anaesthetists.
1	.. Ear, Nose and Throat Surgeon.
11	.. General Practitioners.
1	.. Urologist.
1	.. Assistant Urologist.
1	.. Gynaecologist.
1	.. Assistant Gynaecologist.
1	.. Ophthalmic Surgeon.
1	.. Orthopaedic Surgeon.
1	.. Assistant Orthopaedic Surgeon.
1	.. Pathologist.
1	.. Physician.
1	.. Assistant Physician.
2	.. Surgeons.
2	.. Assistant Surgeons.
1	.. Neuro-Psychiatrist.

Appointments will be made for a period of five years with effect from 2 January 1954, but shall be terminable by either party upon the giving of three months' notice in writing.

The annual honorarium payable before the thirty-first day of March of each year shall be calculated by multiplying the average daily number of in-patients treated in the hospital during the preceding calendar year by £10, provided that no member of the honorary medical staff shall be apportioned more than £105 per annum.

Applications stating age, qualifications, etc. should be forwarded to reach the Medical Superintendent, Central Office, Mountain Road, Woodstock, not later than noon on Friday, 6 November 1953.

Department of Mines

LOCUM TENENS FOR MEDICAL OFFICER AT THE STATE ALLUVIAL DIGGINGS, ALEXANDER BAY

The services of a bilingual general medical practitioner (preferably single) are required at the State Alluvial Diggings, Alexander Bay, during the period 14 December 1953, to 13 February 1954.

The remuneration is £80 per month (all inclusive) plus free board and lodging in the single quarters.

A free return ticket for air travel between Cape Town and Alexander Bay will be provided and motor transport is available for use on duty.

The local hospital (32 beds) is well equipped. Recreation facilities exist.

Applications should be addressed to the General Manager, State Alluvial Diggings, Alexander Bay, Namaqualand, and should reach that office on or before 15 November 1953.

M.M.Staff 1/28/7
(42518)

Bridgman Memorial Hospital Johannesburg

HOUSE SURGEONS IN OBSTETRICS

Applications are invited from medical practitioners for three posts of House Surgeon in Obstetrics at the above non-European Maternity Hospital for the period 1 February 1954 to 31 July 1954 inclusive. Successful applicants may be required to lecture to pupil midwives.

Salary £240 per annum plus married or single cost-of-living allowance, board, lodging and laundry.

Closing date for applications: 16 November 1953.

Applications with a complete list of previous experience should be sent to the Superintendent, Bridgman Memorial Hospital, High Street, Mayfair, Johannesburg.

Provinsiale Administrasie van die Kaap die Goeie Hoop

ERE-MEDIESE AANSTELLINGS

Aansoeke word ingewag van geregistreerde mediese geneeshere onder die ouderdoms grens van sestig jaar vir aanstelling tot die volgende poste by die Rondebosch en Mowbray Hospitaal, Rondebosch.

Getal Poste	*Benoeming*
1	Ere Narkotiseur.
2	.. Assistent Narkotiseurs.
1	.. Oor, Neus en Keel Chirurg.
11	.. Algemene Praktisyns.
1	.. Uroloog.
1	.. Assistent Uroloog.
1	.. Geniko.oog.
1	.. Assistent Genikoloog.
1	.. Oogarts.
1	.. Ortopediese Chirurg.
1	.. Assistent Ortopediese Chirurg.
1	.. Patoloog.
1	.. Internis.
1	.. Assistent Internis.
2	.. Chirurge.
2	.. Assistent Chirurge.
1	.. Neuro-Psigiator.

Lede van die ere-mediese personeel sal vir 'n tydperk van vyf jaar aangestel word vanaf 2 Januarie 1954 maar aanstellings kan deur enigeen van die partye beëindig word deur skriftelike kennisgewing van drie maande.

Die jaarlikse honorarium betaalbaar aan die ere-mediese personeel voor die een-en-dertigste dag van Maart elke jaar sal bereken word deur die gemiddelde daaglikse getal binnepasiente wat gedurende die voorafgaande kalenderjaar in die hospitaal is, met £10 vermenigvuldig, met dien verstande dat geen lid van die ere-mediese personeel meer as £105 per jaar mag ontvang nie.

Aansoeke wat melding maak van ouderdom, kwalifikasies, ensovoorts, moet gestuur word aan die Mediese Superintendent, Sentrale Kantoor, Mountainweg, Woodstock, om hom nie later as twaalf middag op Vrydag, 6 November 1953, te bereik nie.

Transvaal Provincial Administration

VACANCIES: TRANSVAAL PUBLIC HOSPITALS

Applications are invited from suitably qualified candidates for the undermentioned posts at Public Hospitals in the Transvaal.

Applications should be addressed to the Medical Superintendents of the undermentioned Hospitals concerned and should contain full particulars as to the age, professional and academic and language qualifications, experience and conjugal status of the applicant and should further indicate the earliest date upon which duties can be assumed. Copies, only, of recent testimonials to be attached.

Cost-of-living allowance payable at present to full-time employees:

Salary	*Cost-of-Living Allowance. Married*	*Single*
Over £350 per annum	£320 per annum	£100 per annum

Full-time employees receive in addition to their salaries and cost-of-living allowance, the following privileges:

Leave and rail concession.

Successful candidates will be required to submit satisfactory certificates as also to submit to a medical examination at the hospital concerned.

Application forms are obtainable from any Transvaal Provincial Hospital or the Provincial Secretary, Hospital Services Branch, P.O. Box 2060, Pretoria.

The closing date of applications for undermentioned posts will be 26 October 1953.

Hospital	*Post*	*Emoluments*	*Remarks*
Johannesburg Hospital Board and the University of the Witwatersrand	Anaesthetist	£1,800	Registered medical practitioner. Higher qualifications in Anaesthetics a recommendation.

(A42767)

Provincial Administration of the Cape of Good Hope

HONORARY MEDICAL APPOINTMENTS

Applications are invited from registered medical practitioners who are under the age of sixty years for appointment to the under-mentioned posts at the Woodstock Hospital, Woodstock.

Number of Posts	*Designation*
1	Honorary Anaesthetist.
1	,, Dermatologist.
1	,, Ear, Nose and Throat Surgeon.
9	,, General Practitioners.
1	,, Gynaecologist.
2	,, Assistant Gynaecologists.
1	,, Ophthalmologist.
1	,, Orthopaedic Surgeon.
1	,, Assistant Orthopaedic Surgeon.
1	,, Paediatrician.
1	,, Assistant Paediatrician.
1	,, Physician.
1	,, Assistant Physician.
1	,, Surgeon.
1	,, Assistant Surgeon.
1	,, Urologist.

Appointments will be made for a period of five years with effect from 2 January 1954, but shall be terminable by either party upon the giving of three months' notice in writing.

The annual honorarium payable before the thirty-first day of March of each year shall be calculated by multiplying the average daily number of in-patients treated in the hospital during the preceding calendar year by £10, provided that no member of the honorary medical staff shall be apportioned more than £105 per annum.

Applications stating age, qualifications, etc. should be forwarded to reach the Medical Superintendent, Central Office, Mountain Road, Woodstock, not later than noon on Friday, 6 November 1953.

Provinsiale Administrasie van die Kaap die Goeie Hoop

ERE-MEDIESE AANSTELLINGS

Aansoeke word ingewag van geregistreerde mediese geneeshere onder die ouderdoms grens van sestig jaar vir aanstelling tot die volgende poste by die Woodstock Hospitaal, Woodstock.

Getal Poste	*Benoeming*
1	Ere Narkotiseur.
1	,, Dermatoloog.
1	,, Oor, Neus en Keel Chirurg.
9	,, Algemene Praktisyne.
1	,, Genikoloog.
2	,, Assistent Genikoloë.
1	,, Oogarts.
1	,, Ortopediese Chirurg.
1	,, Assistent Ortopediese Chirurg.
1	,, Kinderarts.
1	,, Assistent Kinderarts.
1	,, Internis.
1	,, Assistent Internis.
1	,, Chirurg.
1	,, Assistent Chirurg.
1	,, Uroloog.

Lede van die ere-mediese personeel sal vir 'n tydperk van vyf jaar aangestel word vanaf 2 Januarie 1954 maar aanstellings kan deur enigeen van die partye beëindig word deur skriftelike kennisgewing van drie maande.

Die jaarlikse honorarium betaalbaar aan die ere-mediese personeel voor die een-en-dertigste dag van Maart elke jaar sal bereken word deur die gemiddelde daaglikse getal binnepasiente wat gedurende die voorafgaande kalenderjaar in die hospitaal is, met £10 vermenigvuldig, met dien verstande dat geen lid van die ere-mediese personeel meer as £105 per jaar mag ontvang nie.

Aansoeke wat melding maak van ouderdom, kwalifikasies, ensovoorts, moet gestuur word aan die Mediese Superintendent, Sentrale Kantoor, Mountainweg, Woodstock, om hom nie later as twaalf middag op Vrydag, 6 November 1953, te bereik nie.

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Provincial Administration of the Cape of Good Hope

HONORARY MEDICAL APPOINTMENTS

Applications are invited from registered medical practitioners who are under the age of 60 years for appointment to the undermentioned posts at the Victoria Hospital, Wynberg.

1 Surgeon
2 Assistant Surgeons
1 Physician
1 Assistant Physician
1 Ophthalmic Surgeon
1 Assistant Ophthalmic Surgeon
1 Assistant Ophthalmic Surgeon (Refractionist)
1 Urologist
1 Gynaecologist
1 Assistant Gynaecologist
1 Orthopaedic Surgeon
1 Assistant Orthopaedic Surgeon
1 Ear, Nose and Throat Surgeon
1 Paediatrician
1 Specialist in Physical Medicine
1 Senior Anaesthetist
4 Assistant Anaesthetists
1 Dermatologist
8 General Practitioners (Surgical Division)
6 General Practitioners (Medical Division)

Appointments will be made for a period of five years with effect from 2 January 1954, but shall be terminable by either party upon the giving of three months' notice in writing.

The annual honorarium payable before 31 March of each year shall be calculated by multiplying the average daily number of in-patients treated in the hospital during the preceding calendar year by £10, provided that no member of the honorary medical staff shall be apportioned more than £105 per annum.

Applications stating age, qualifications, etcetera, should be forwarded to reach the Medical Superintendent, Central Office, 58 Loop Street, Cape Town, or P.O. Box 1487, Cape Town, not later than noon on Friday 6 November 1953.

(A560613)

Provinsiale Administrasie van die Kaap die Goeie Hoop

ERE-MEDIESE AANSTELLINGS

Aansoeke word ingewag van geregistreerde mediese geneeshere onder die ouderdom grens van 60 jaar vir aanstelling tot die volgende poste by die Victoria-hospitaal, Wynberg.

1 Chirurg
2 Assistent-Chirurge
1 Medikus
1 Assistent-Medikus
1 Oftalmoloog
1 Assistent-Oftalmoloog
1 Assistent-Oftalmoloog (Refraksionis).
1 Uroloog
1 Ginekoloog
1 Assistent-Ginekoloog
1 Ortopediese Chirurg
1 Assistent-Ortopediese Chirurg
1 Oor, Neus en Keel Chirurg
1 Spesialis in Pediatrie
1 Spesialis in Fisiese Medisyne
1 Narkotiseur
4 Assistent-Narkotiseure
1 Dermatoloog
8 Algemene Geneeshere (Chirurgiese Afdeling)
6 Algemene Geneeshere (Mediese Afdeling)

Lede van die ere-mediese personeel sal vir 'n tydperk van vyf jaar aangestel word vanaf 2 Januarie 1954 maar aanstellings kan deur enigeen van die partye beëindig word deur skriftelike kennisgewing van drie maande.

Die jaarlikse honorarium betaalbaar aan die ere-mediese personeel voor 31 Maart elke jaar sal bereken word deur die gemiddelde daaglikse getal binnepasiente wat gedurende die voorafgaande kalenderjaar in die hospitaal is, met £10 te vermenigvuldig, met dien verstande dat geen lid van die ere-mediese personeel meer as £105 per jaar mag ontvang nie.

Aansoeke wat melding maak van ouderdom, kwalifikasies, ensovoorts, moet gestuur word aan die Mediese Superintendent, Sentrale Kantoor, Loopstraat 58, of Posbus 1487, Kaapstad, om hom nie later as 12-middag op Vrydag, 6 November 1953 te bereik nie.

(A560613)

Provincial Administration of the Cape of Good Hope/University of Cape Town:

JOINT MEDICAL STAFF FOR GROOTE SCHUUR AND OTHER TEACHING HOSPITALS : VACANCY

1. Applications are invited from registered medical practitioners (registered specialists) for appointment to the following post:

Department of Ear, Nose and Throat: 1 post of Medical Practitioner, Grade G. Salary £182 per annum per session (2½ sessions).

2. The conditions of service are prescribed in terms of Hospital Board Service Ordinance No. 19 of 1941, as amended, and the regulations framed thereunder.

3. The Joint Medical Staff is required to serve jointly the Provincial Administration of the Cape of Good Hope and the University of Cape Town.

4. Candidates are required to have not less than three years experience after registration as a Specialist in the speciality in which the vacancy exists.

5. A session shall be four hours per week, not necessarily continuous clinical and/or teaching work.

6. Application must be made on the prescribed form, Staff 23, which is obtainable from the Director of Hospital services, P.O. Box 2060, Cape Town, or from the Medical Superintendent of any provincial hospital or Secretary of any School Board in the Cape Province.

7. The completed application forms must be addressed to the Director of Hospital Services, P.O. Box 2060, Cape Town, and must reach him not later than 18 November 1953. Candidates must state the earliest date on which they can assume duty.

(A562768)

Provinsiale Administrasie van die Kaap die Goeie Hoop/Universiteit van Kaapstad:

GESAMENTLIKE MEDIESE PERSONEEL VIR GROOTE SCHUUR EN ANDER OPLEIDINGS-HOSPITALE : VAKATURE

1. Aansoeke word ingewag van geregistreerde geneeshere (geregistreerde spesialiste) vir aanstelling tot die volgende pos:

Departement van Oor, Neus en Keel: 1 pos van Geneesheer, Graad G. Salaris £182 per jaar per sessie (2½ sessies).

2. Die diensvoorwaardes word voorgeskryf ingevolge die Ordonnansie op Hospitaalraadsdiens nr. 19 van 1941, soos gewysig, en die regulasies wat daarkragtens opgestel is.

3. Die Gesamentlike Mediese Personeel word vereis om die Provinsiale Administrasie van die Kaap die Goeie Hoop en die Universiteit van Kaapstad gesamentlik te dien.

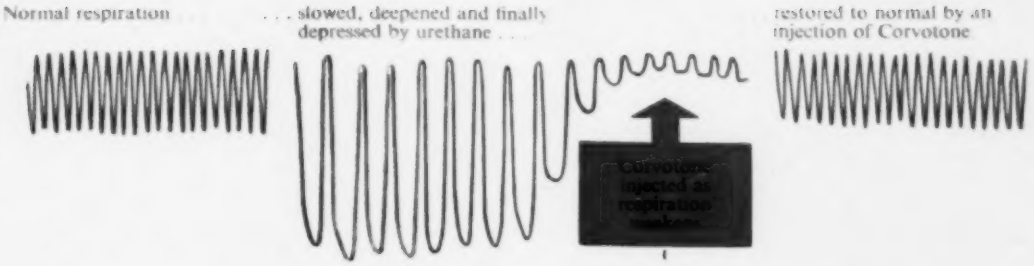
4. Kandidate moet minstens drie jaar ondervinding na registrasie as 'n Spesialis in die spesialiteit waarin die vakature bestaan, opgedoen het.

5. 'n Sessie is vier uur per week in verband met kliniese en/of opleidingswerk, maar is nie noodwendig onafgebroke nie.

6. Aansoek moet gedoen word op die voorgeskrewe vorm (Staf 23), wat verkrygbaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige provinsiale hospitaal of by die Sekretaris van enige Skoolraad in die Kaapprovinsie.

7. Die ingevulde aansoekvorms moet aan die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, gerig word en moet hom uiters op 18 November 1953 bereik. Kandidate moet die vroegste datum meld waarop hulle diens kan aanvaar.

(A562768)



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